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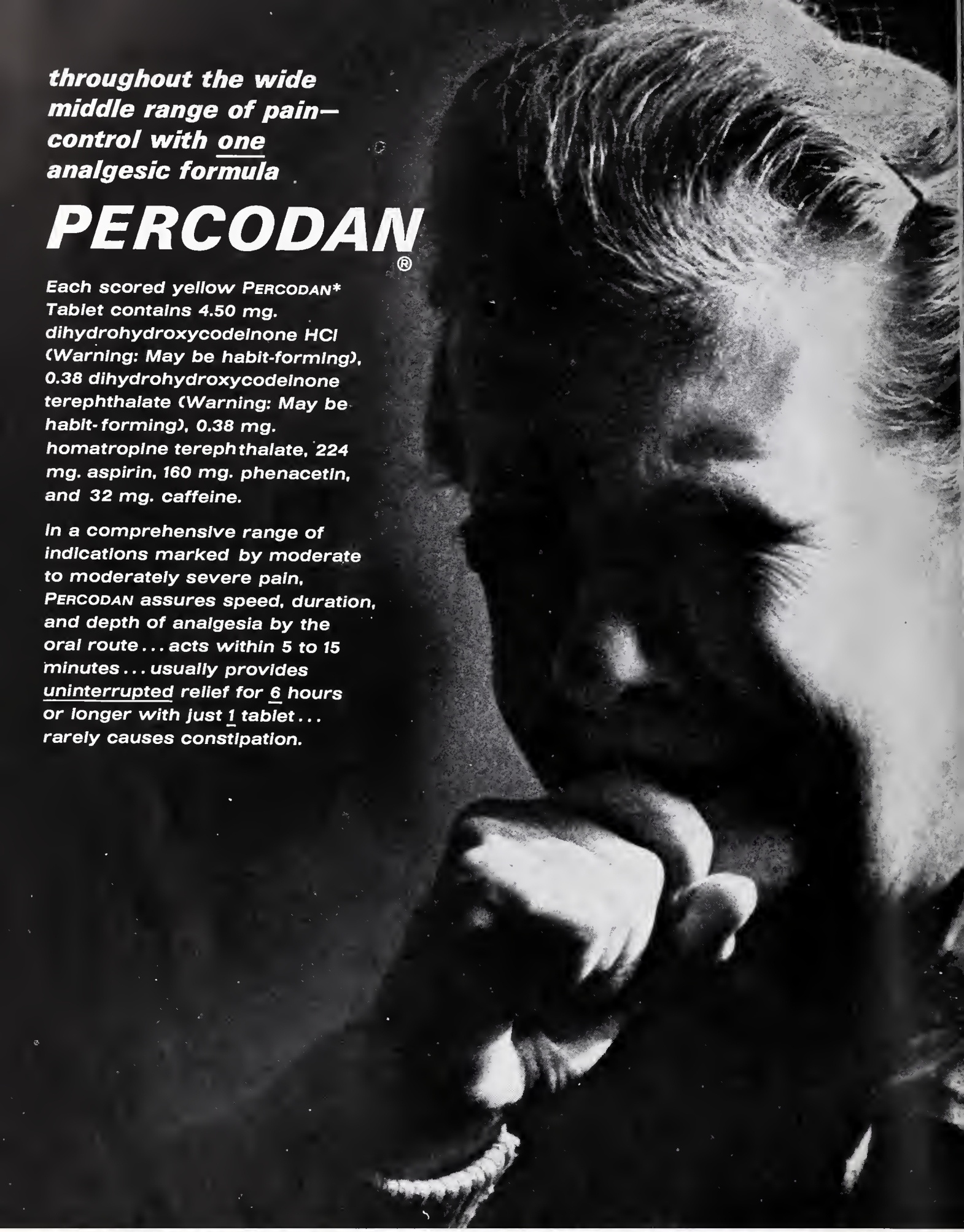
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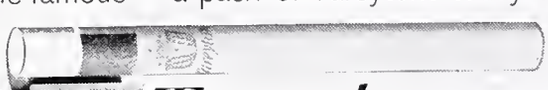
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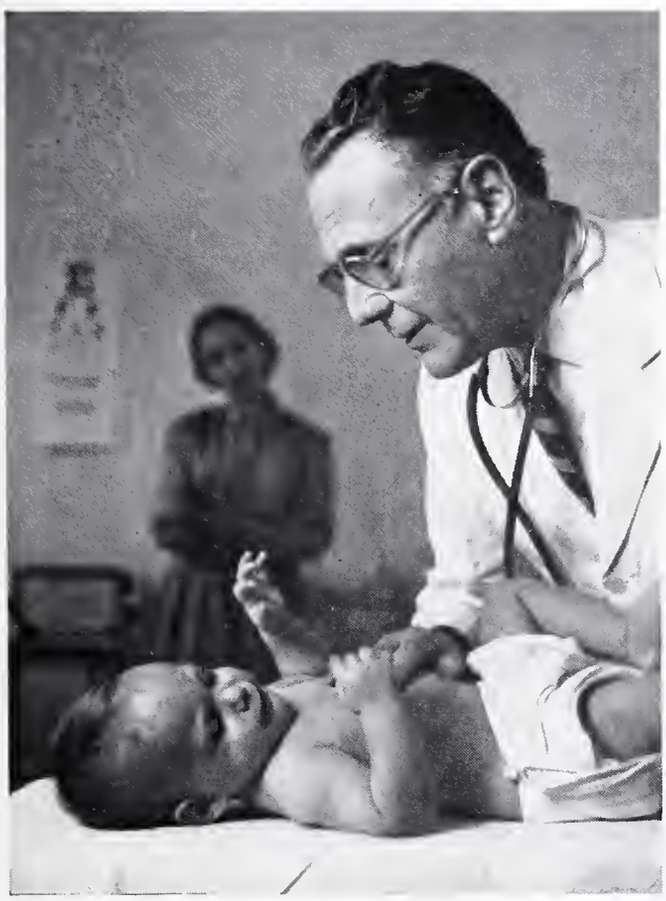
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References: 1. Wilson, J. F.; Heiner, D. C., and Lahey, M. E.: J. Pediat. 60:787, 1962. **2.** Committee on Nutrition, Collected Reprints, 1956-1962, Evanston, Ill., American Academy of Pediatrics, 1963, p. 45. **3.** Beal, V. A.: Pediatrics 20:448, 1957. **4.** Reisner, E. H., Jr.: Penn. Med. J.: 63:49, 1960. **5.** Marsh, A., et al.: Pediatrics 24:404, 1959.

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The author of this article has a simple, direct, unabashed message for you: "Asthma can be cured!"

Therapeutic Aspects of Asthma, Emphasizing the Role and Control of Cough

LOUIS E. PRICKMAN, M.D., *Rochester, Minnesota*

• *Most patients and physicians are not satisfied with the current treatment of asthma. A somewhat different approach to the problem is presented herein, and the reasons are given for any unconventional suggestions which have been made. It seems important to explain the rationale of the treatment to the patient. Even a child will cooperate better if he understands why we do certain things to relieve and prevent his asthma.*

There is no support whatever for the question occasionally heard, "Doctor, there really isn't much you can do for asthma, is there?" A great deal can be done and needs to be done. An intelligent, optimistic approach by both patient and physician is needed. Cures have been and can be obtained.

I would know exactly what to do if I had asthma.

IT IS MY purpose here to rationalize the treatment of asthma so that physicians and patients alike will understand why certain measures need to be carried out and, as importantly, why others must be avoided, if asthma is to be controlled or, better yet, cured.

Let us examine asthma from a somewhat different point of view. In so doing, if certain unorthodox comments or suggestions are made, it is hoped that they will be evaluated with an open mind, because, after all, . . . "the good American doctor . . . is sceptical toward the data of his own profession, welcomes discoveries which upset his previous hypotheses, and is still animated by humane sympathy and understanding."[3]

PATHOLOGIC ASPECTS

The fundamental lesion in asthma is inflammation (not necessarily infection) of the air passages. Examination of a section of a bronchus from a patient with asthma typically will reveal a narrowed lumen containing mucus. The mucous membrane itself is thickened and lies in folds; the basement membrane is thickened; the musculature is hypertrophied and the submucosal areas are infiltrated with cellular elements, all evidence of inflammation and bronchospasm.

When the bronchoscopist visualizes the air passages of a patient who has asthma, he encounters narrowed, red, inflamed-appearing, irritable bronchi that are covered with excess mucus. These signs are observed regardless of whether the basis of the asthma is extrinsic (allergic) or intrinsic (asthmatic bronchitis).

Since there is no medication which will cure inflammation, and since there is no medication which will cure asthma, one must go back to simple fundamentals if inflammation in the air passages is to be treated successfully. Treatment of asthma proceeds in three phases: first, the causes of inflammation in air passages must be removed; second, any complications of asthma must be re-

Based on lectures given at The Queen's Hospital, Honolulu, November 2, 1962, and at Kuakini Hospital, Honolulu, November 9, 1962.

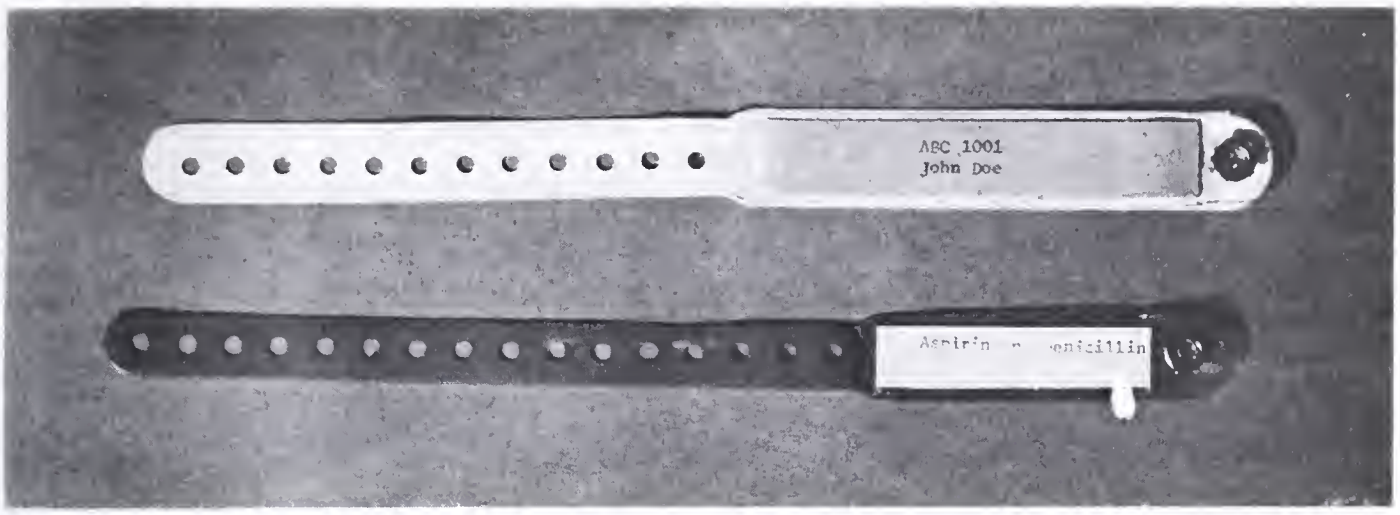


FIG. 1.—*Red plastic wristband worn in the hospital to indicate the nature of the patient's allergy. (Reproduced with permission from: Prickman, L. E.:* Prevention and Management of Anaphylactic Reactions. *Minnesota Med. 45:905-908 [Sept.] 1962.)*

moved or treated; last, the air passages must be put at rest to attain complete healing. Given the opportunity, nature will heal inflammation whether it is in the air passages, bones, skin or eye. A fractured bone which is being constantly moved will not heal; likewise, conjunctivitis or bronchitis will not heal as long as the membranes concerned are being irritated, as by smoke or dust particles.

There are a great many ways of irritating bronchial mucous membranes, and they have one feature in common: namely, they all produce cough. Coughing is very irritating to the air passages, and the patient with asthma soon recognizes that anything which induces coughing also induces asthma. Let us take advantage of this fact, and build our treatment of asthma on the assumption that anything we do to avoid coughing will reduce or eliminate wheezing and asthma, and thereby permit inflamed bronchi to heal.

The causes of asthma must be recognized and removed if the need for coughing is to be eliminated. Since the causes for asthma vary with each individual, a thorough search for causes and complications must precede the charting of any worthwhile, productive course of action.

ALLERGIC ASTHMA

The part played by allergy in causing asthma is well recognized. We all know people who cough, wheeze and become short of breath when they are around cats, for instance. When you are allergic to something, nature is trying to tell you to stay away from it. If you get the message and stay away from cats, you don't get cat asthma. You do not need "shots" (desensitization) with cat-dander extract, you simply avoid all association with cats. This same principle tells you to avoid any drugs to which you are sensitive, such as penicillin, aspirin, Apresoline, and others. No "shots"—simply meticulously avoid them. It is well worthwhile to wear a tag or to carry a card warning others of your allergy to drugs or serums or to insects such as bees or wasps, so that others may be made aware of your particular allergic idiosyncrasy or hypersensitivity to other agents, should an allergic emergency render you helpless. The hospitalized patient may be tagged with a red plastic wrist band,[2] in the window of which is typed the drug or food to which the patient is allergic, thus warning the medical, nursing, anesthesia, and surgical staff not to administer such a preparation under any circumstances (Fig. 1).

When sensitivity to pollen is the cause of asthma which occurs only during the hay fever season, one should again remember the principle of getting away from the pollen that causes your asthma. This can be accomplished by sleeping in a closed bedroom that is supplied only with filtered air, and by working in an air-conditioned office (filtered air) and having air-conditioning in the car, or best yet—travel to an area in which the offending pollen does not occur. When similar symptoms are produced by flowers or flowering shrubs in or close to your home, they must be eliminated from your environment. One should not lose sight of the fact that when it is not possible to get away from airborne pollens such as those from trees, grasses, and weeds, it is still possible to carry out a program of hyposensitization with an expectancy of more than 80 per cent relief of the symptoms of cough and wheezing.

Another illustration of the all-important principle of avoiding that to which you are sensitive is the incident of the farmer who related on careful questioning that he experienced asthma only in his home, not in the barn and not when he was around animals, chickens, or grain dust, which are offenders so often reported by members of farm families. He said he could not determine what it

was in the house which caused his difficulty. Fortunately, his wife spoke up. She said, "John, don't you remember you have to get up and get out of the room every time the kids jump up and down on the davenport?"

The proper treatment in such an instance is to get rid of the davenport, to subject the contents of the room to a thorough cleaning with a vacuum cleaner to remove davenport dust, and to substitute a davenport with different type of covering and stuffing. Injections of house-dust antigen are not indicated in such a case. If house dust does cause cough and wheezing, the source of the house dust (feathers, coverings, or stuffing of furniture, mattresses, rugs and pads, drapes, and so on) must be found and eliminated.

A good procedure to follow when house dust is suspected is to sniff the air as dust is raised with a whisk broom from coverings, or while dust is being dislodged by beating inside stuffed furnishings. This usually will demonstrate if one is sensitive to house dust, the actual source of the offending dust. The taking of desensitization injections of extracts of dust from someone else's house is illogical, and it makes no better sense to receive desensitization injections of an extract of your own house dust if the source of the dust is left undisturbed. When the source of the dust is eliminated, desensitization becomes superfluous and unnecessary. Justification of all the injections of extracts of house dust used today is hard to find.

Do not be discouraged if an allergic basis for coughing and wheezing cannot be found. There are many causes of asthma other than special sensitivity to house dust, and if dust seems not to be the offender, these other causes should be sought next, rather than to inject patients with extracts of dust, as so often happens, without any rationale.

Many other practical and theoretical considerations of allergic asthma must be omitted from consideration here, but the patient should remember nature's prime admonition to allergic people: "Stay away from anything to which you are allergic, be it drugs, food, pollens, dust, animals, insects, or anything else in your environment or occupation to which you are sensitive. If you do, you will avoid much coughing and wheezing, if your asthma is on an allergic basis."

INTRINSIC ASTHMA

Many people have asthma which is caused by intrinsic factors. In such a category is asthma which follows colds (virus infections and, later, bacterial infections of the respiratory tract) or which is associated with chronic bronchitis, sinusitis, or pneumonitis of various types and degrees. Such infections are irritating to the respiratory tract; they induce coughing, wheezing, and asthma.

What precautions can be taken to prevent this type of asthma? The best prophylactic measures, in addition to avoidance of fatigue and exposure, are (1) avoid people who have colds, (2) wear a surgical mask if you have asthma and do not wish to acquire a cold which other members of the family have, and (3) cover your nose and mouth inconspicuously with your handkerchief to prevent the inhaling of viruses and bacteria from people who are coughing near you, as may happen in church, movies, buses, or any congested areas. A surgical mask is easily made or readily purchased, and is one of the most often neglected or overlooked measures for the prevention of spreading of colds. Needless to say, to the asthmatic, a cold may mean weeks of disability and even the expense of hospitalization.

If the patient who has asthma does acquire a cold, he should *go to bed at once* and remain there, drinking much fluid and obtaining plenty of rest. He may sleep, read, watch television presentations, knit, or write, and have meals, in bed; he should get up only for the toilet. Since at present only nature knows how to care for a cold (virus infection), since physicians have no prophylactic vaccine for colds as yet, and since no antibiotic agent will cure or prevent a cold, nothing less than rest in bed will keep an early cold in check and prevent bronchitis, cough, and asthma.

Steam inhalations, with or without added menthol crystals, properly given, also may help. A few days in bed at the *onset* of a cold may prevent a winter of asthma. Patients know this and physicians know it, but many times the patient who faces incipient asthma simply does not consider himself ill enough to go to bed at the onset of a cold, and so the golden opportunity for avoidance of a prolonged attack of intrinsic asthma is missed. A neglected cold may progress to secondary bacterial bronchitis or pneumonitis, in which case cultures of the sputum are indicated and appropriate chemotherapy should be given, whether fever is present or not. Yearly vaccination against influenza is strongly recommended for all patients who have asthma.

When purulent sinusitis complicates asthma it is usually necessary to provide adequate permanent drainage of the infected sinuses before asthma can be controlled. Symptomatic treatment of asthma is always disappointing and ineffective in the presence of chronic sinusitis.

NEUROGENIC FACTORS IN ASTHMA

Neurogenic factors are always important in causing or aggravating asthma. Asthma is not a psychosis, although one may rarely encounter a patient with asthma who has a concomitant psychosis, in which case the latter may require the

assistance of a psychiatrist. The nervous factors which aggravate asthma generally do not require the attention of a psychiatrist. It is certainly easy to understand how a person who cannot get his breath will feel nervous, tense, anxious, and insecure. The asthmatic person who has to tolerate dyspnea and wheezing for hours before he can be relieved is naturally apt to become panic stricken.

One of the best measures to relieve or prevent nervousness and panic in an asthmatic patient is to teach him how to relieve his asthma promptly, just as a physician or a nurse would do. This is easily accomplished by teaching the patient to inject a small quantity of epinephrine (¼ cc of 1:1000), which can be repeated if necessary within 20 to 30 minutes. He should be taught to inject the dose of epinephrine *early,* without delay, whenever his asthma is not relieved by inhalations of nebulized Isuprel hydrochloride, Norisodrine sulfate or epinephrine or similar preparations. This is the answer to his often-heard question: "What shall I do if I have another one of those awful attacks?"

The self-administration of epinephrine subcutaneously actually is easier than to inject insulin into oneself, because there is no problem of adjusting the dosage. Epinephrine (1:1000) is now available in disposable carpules with disposable needles. It is available in 1 cc carpules (Wyeth) and the patient simply injects about a quarter of the contents of the syringe as one dose.

Epinephrine is safe and effective; but whenever it becomes necessary to use it many times a day, the patient should see his physician, because a need of such frequency indicates that something is wrong. Perhaps respiratory infection or sinusitis has complicated the asthmatic problem of such a patient, or perhaps he is exposed to some respiratory irritant to such a degree that symptomatic remedies, such as epinephrine, are not effective. In an instance like the foregoing it should not be judged that epinephrine is not a good and effective remedy or that the patient is necessarily "epinephrine fast." Rather, thoughtful review of the patient's problem by an interested physician usually will determine why the patient is not doing well and why epinephrine does not promptly relieve his symptoms.

When a patient thoroughly understands his problem as it relates to asthma, and when he can stop an attack of asthma as soon as it begins, he will regain his sense of security and nervous factors arising from asthma will be almost eliminated.

OTHER RESPIRATORY IRRITANTS

There are a number of common respiratory irritants which aggravate asthma, whether the asthma is caused by an allergy and infection or is neurogenic. It is an ironic fact that most patients are able to recognize the factors which aggravate their asthma, but generally do not take the precautions necessary to avoid them.

Smoke, Smoking, Fumes. Smoking is tabu, *verboten,* forbidden if you have asthma. This dictum applies to the smoking of cigarettes, cigars, or pipes, and to the use of asthma cigarettes and inhalation of the smoke of asthma powders. No patient who has asthma should smoke anything, in any amount. Just as a sore, red, inflamed eye will not heal if smoke is blown into it intermittently, so also inflamed air passages will never heal so long as a patient smokes. Smoking induces coughing and coughing induces asthma. Occasionally one encounters patients with asthma who prefer to continue to smoke and to endure asthma, but the physician can promise such a patient that his asthmatic bronchitis will become progressively worse with the passage of time, and that indeed some degree of emphysema will almost certainly develop, and that he may become completely incapacitated, a respiratory cripple.

Other sources of smoke—such as a bonfire, a building fire, a forest fire, or a volcano, for instance —must also be meticulously avoided. The inhalations of fumes and smog likewise induce coughing and asthma and of course must be avoided.

Dust. The inhalation of dusts such as house dust, road dust, and occupational dusts often induces coughing, wheezing, and dyspnea, and must always be avoided by the asthmatic patient. Monkeypod wood workers, please note.

Exertion. Exertion is followed by coughing, wheezing, and dyspnea in the asthmatic patient. The patient who has asthma never should exert himself to the point of aggravating his asthma. This counsel is particularly difficult for asthmatic children to understand, but restriction of physical exertion is absolutely necessary, since the alternative is coughing, dyspnea and a flare-up of asthma.

Changes in Temperature — Asthma Pillow. Sudden changes in temperature are not well tolerated by the mucous membranes of the asthmatic patient. Walking from a warm room (72° F.) to the outdoors, where the air is cold and frosty, will promptly induce bronchospasm, coughing, and wheezing in the asthmatic patient. Even stepping out to pick up the newspaper or a bottle of milk on a cold morning may bring about coughing and asthma. Other patients are so hypersensitive to changes in temperature that walking in or out of air-conditioned buildings in the summertime will induce coughing and asthma.

Patients often will place a muffler, a glove, coat collar, or handkerchief over their nose and mouth to warm the inhaled cold air and thereby avoid the sudden change in temperature which



FIG. 2.—*Asthma pillow to temper the effects of sudden changes of temperature.*

induces asthma. A more practicable method is to make a small pillow about the size of an adult's palm and hold this over the nose and mouth whenever sudden changes in temperature are encountered (Fig. 2). The patient can readily carry this small asthma pillow in his pocket or her pocketbook and have it ready to use. Such pillows can be homemade in several ways. A common wool muffler can be folded over and over until it is the size of a beanbag, and the edges can be sewn and trimmed to make a very satisfactory asthma pillow. Also, wool suiting or coat material can be cut to size and stuffed with wool or Dacron to accomplish the same effect. It is not necessary to keep the nose and mouth covered at all times, since the respiratory membranes tolerate either cold air or hot air after a few minutes' exposure. It is the sudden change of temperature that is not tolerated by the patient who has asthma. The inconspicuous use of an asthma pillow covering the nose and mouth is essential for the patient who is troubled by sudden changes in temperature. Such a pillow also is useful when either cold winds or flying dusts are encountered. In addition, as one might expect, certain patients with heart disease who are intolerant to sudden changes in temperature have found a pillow of this type useful. The production and sale of asthma pillows is an excellent project for women's auxiliaries of hospitals in areas in which extremes of temperature are encountered. For some reason patients seem reluctant to make them for themselves.

Hard Laughing. Hard laughing frequently is followed by coughing and wheezing in the patient who has asthma. Asthmatic patients are therefore advised to express their amusement with a smile, a grin, or a gentle chuckle, and they are urged not to indulge in a belly laugh. Similarly, too much talking may aggravate asthma.

From the foregoing it is apparent, and should be axiomatic, that the patient who has asthma must avoid anything which induces coughing, since coughing aggravates attacks of asthma.

MUCUS IS PROTECTIVE

Overcoughing To Raise Mucus. But what about the patient who overcoughs to raise mucus? This is an extremely common cause of asthma. Overcoughing is indulged in by reason of the patient's false assumption that mucus is noxious, or toxic, and that it must be coughed out of the lungs at whatever cost. Coughing to raise mucus always aggravates asthma, just as does coughing induced by smoking, exertion, or colds. The end result is the same: more asthma.

The patient who has asthma must be told that mucus is a normal secretion of the mucus membrane lining the air passages, and that it is nature's protective "ointment" which is secreted to coat inflamed air passages. Mucus is secreted to form a protective blanket on which smoke particles will land instead of becoming lodged in the membranes; similarly, it protects the membranes from the deleterious effects of cold air, sudden changes in temperatures, and inhaled allergens such as pollens, danders, and dusts, and it is the first line of defense against inhaled viruses and bacteria.

Mucus is therefore the patient's best friend; it should be left on the membranes to protect them, instead of being vigorously expelled by coughing. When mucus is coughed out of the air passages, nature secretes more mucus at once, since inflamed membranes need the protection of a coating of mucus. Thus, coughing to raise mucus becomes a vicious cycle: the more mucus is coughed out, the more mucus is formed. Nature will not permit the inflamed membranes to dry out.

Many patients exhaust themselves trying to expel mucus from their lungs; it is common for asthmatic patients in the hospital to fill a wastebasket with tissues containing mucus that was raised during the night. Then, as is to be expected, their excessive coughing greatly worsens their asthma, in spite of the resort to bronchodilators, steroids, expectorants, or other medications.

What can be done to stop this vicious cycle of overcoughing to raise mucus? It is not easy, but

something can be done if the patient is intelligent and cooperative, and if his physician will take the time to explain all the factors involved. First, the patient must understand that mucus is secreted in excess if he has a cold, if he smokes or if he inhales something to which he is sensitive. Next, he must be instructed to avoid all respiratory irritants which *induce the excessive formation of mucus*. These irritants have been described in some detail in this paper. It is further assumed that the causes and complications of the patient's asthma have been investigated and treated appropriately by his physicians, since the excessive secretion of mucus will persist for protective reasons as long as extrinsic or intrinsic causes of asthma are present. Removal of the causes and complications of asthma and avoidance of the common respiratory irritants which induce coughing are necessary before *excessive* secretion of mucus can be stopped.

Before we proceed further in describing methods for the control of overcoughing to raise mucus, two important precautions should be called to the attention of the physician.

DON'T FORBID COUGHING

First, the patient *never should be told not to cough*. He should be advised to *avoid the things* (detailed above) *which make him cough*. After all, coughing is a defensive mechanism. For example, if a fire is started in a wastebasket and a smudge fills the room, all those present in the room will cough and choke and be forced to seek fresh air. There is no alternative. Such coughing is protective and is nature's warning to get away from the smoke and fumes as fast as possible, and to breathe clear air. Now, if one of those present in this smoke-filled room is asthmatic, his coughing will precipitate an attack of asthma. Although deleterious to the asthmatic patient, coughing under such conditions is necessary, protective, and physiologic.

The second precaution is to avoid attempts to control coughing, or even to suppress it, as soon as a patient with asthma is encountered. For example, the patient who is admitted to the hospital in status asthmaticus usually is dehydrated; his mucus is thick, very sticky, and tenacious; and he may be coughing hard to raise mucous plugs and casts from his bronchi. Under such circumstances, before control of overcoughing is attempted, the patient must be well hydrated, expectorants and bronchodilators must be administered, and the causes and complications of his asthma must be investigated and removed. When these measures have been accomplished there will be plenty of time in which to bring the overcoughing under control. It can be seen, therefore, that timing is very important. That is, if the patient stops coughing too soon, the persistence of plugs and casts actually may favor the retention of more secretions and the development of obstructive pneumonitis or other undesirable complications. That stage at which the secretions are thin and easily raised is the one at which instruction of the patient in control of coughing should begin.

The physician, in addition to reassuring the patient that a physiologic quantity of mucus is beneficial and nontoxic, should tell him that in the normal course of events any *excess* mucus present in the air passages is gradually lifted, chiefly by means of cilia, until it reaches the upper limits of the trachea. Then the normal signal for action comes into play in the form of a tickling, or a sensation of an excess quantity of secretion in the throat. The patient should train himself not to cough when this sensation is felt, for if he does cough, he will not only induce bronchospasm and asthma but will remove mucus from all the lower air passages, and this loss must then be promptly replaced by natural secretion.

Rather than coughing when he experiences this sensation, the patient should learn to clear his throat gently, as one commonly does before speaking on the telephone. He can accomplish the same desirable result by saying the negative guttural "hunka." This gentle clearing of the throat does not induce asthma and it does not rid the bronchi of physiologic mucus which should remain in place to protect the inflamed respiratory membranes. If a person has a sore, red eye, he knows better than to rub it vigorously. He rubs it very gently, if at all. Similarly, the patient who has asthmatic bronchitis cannot heal his inflamed air passages if he coughs hard to raise mucus. Gentle clearing of the throat encourages healing and is harmless.

Healing of injured or inflamed air passages or the lungs occurs promptly if the opportunity is presented. Part or all of the lung can be removed surgically and healing follows promptly. Properly treated, uncomplicated pneumonia, tuberculosis, and bronchitis can be healed, and resting of the inflamed tissues is a crucial phase of healing. But resting of bronchial tissues cannot be accomplished in the presence of hard coughing.

SYMPTOMATIC TREATMENT OF ASTHMA

Helpful medications for the relief of the symptoms of asthma are readily available and are effective. For mild bronchospasm and asthma, the inhalation of bronchodilators, such as Isuprel hydrochloride, Norisodrine sulfate, or epinephrine gives prompt symptomatic relief. These agents are safe and are highly recommended. They are mild remedies; we might say that to prescribe them is

like "sending a boy to do a man's work." Because they are mild they must be used early, at the first sign of tightness or wheezing in the chest, and before hard coughing begins. These remedies should be inhaled before the patient retires or when he awakens with a sensation of tightness, and they should be used, if possible, before coughing and asthma begin.

A word of caution should be given about aerosol therapy or the inhalation of powdered medication. If these agents induce coughing, they should not be used. Coughing induces bronchospasm and defeats the purpose of therapy, which is to relieve bronchospasm. Any patient may cough a few times when he first tries to inhale aerosol preparations, but this reaction quickly disappears as he becomes used to inhaling in this manner, unless the medication actually is irritating to his bronchi. Aerosol preparations containing steroids permit the use of smaller daily doses, which is desirable provided the inhalation of these agents thus fortified does not induce coughing or more asthma.

When asthma is not controlled by a few inhalations of these mild remedies, 0.25 cc of a more effective agent, epinephrine (1:1000), should be injected subcutaneously. This should be repeated within 20 to 30 minutes, if necessary. The patient should be encouraged to use these perfectly safe and physiologic remedies without delay. To wait hours before they are used is to invite severe, difficult-to-relieve asthma. Many patients delay taking such remedies because of the mistaken impression that it is harmful to do so, or because they think the effect of such measures will become gradually lessened or because they fear that use of the agents will become a habit. Nothing is farther from the truth, and patients need to be reassured in this regard. They should be told that epinephrine is a normal product of the adrenal glands and that they need it when they have an attack of asthma. The longer they delay supplying the needed epinephrine, the more doses will be needed to relieve their symptoms.

When the patient gives himself epinephrine he should inject it subcutaneously into the lateral aspect of the thigh or into the abdominal wall. Use of these sites permits him to use both hands, which he could not do if he were to inject the agent into his arm.

Preparations containing ephedrine often are taken orally several times daily to relieve bronchospasm. Ephedrine does not prevent asthma, it simply helps to relieve bronchospasm. Many persons take it regularly whether they need it or not. Any patient who uses ephedrine or similar drugs regularly without achieving relief of symptoms should be carefully restudied by his physician. Something is wrong if a patient finds it necessary to use large, repeated doses of either ephedrine preparations or epinephrine.

Aminophylline, administered intravenously incorporated in infusions of glucose or in the form of rectal suppositories or solutions for rectal retention, is extremely helpful in relieving bronchospasm. Sometimes it produces nausea and vomiting, in which case use of the agent may have to be discontinued. Before that is done, however, administration of one of the anti–motion-sickness drugs should be tried because such an agent may control the side effects of aminophylline. Undiluted aminophylline should not be administered intravenously to relieve asthma. It is much safer to use this agent in diluted form in an infusion when it is to be given intravenously.

Antihistaminic agents are occasionally useful in the treatment of asthma, not so much for their antihistaminic effect as for their sedative action. When such proves to be the case, antihistaminic agents as incorporated in diphenhydramine (Benadryl) or tripelennamine (Pyribenzamine) hydrochloride may be useful and safe. These preparations can be given orally or added to the infusion which the patient is to receive intravenously.

IODIDES AND CHLORIDES

Iodides and ammonium chloride are the two most used and most effective expectorants, but they will be of no value whatever unless the patient is well hydrated. In other words, water is more important in combating dehydration than the so-called expectorants. The difference between thick, sticky, tenacious sputum, with or without mucous plugs, and thin, easily raised mucus, is the presence of water in the latter. Hydration is best accomplished by the intravenous administration of a five per cent solution of glucose plus the oral administration of fluids (water, juices, and so on) at a rate of at least a glass of fluid taken during each waking hour.

Ten drops of potassium iodide in a saturated solution taken three times a day usually is helpful against asthma. Larger doses often are given to children who have asthma. It is important to stop iodide therapy if a rash develops or if the salivary glands become swollen. To continue iodide therapy in the face of intolerance or hypersensitivity to iodides is to invite serious consequences, even disaster. All patients should understand this hazard. It is recommended that a warning be appended to each prescription for iodides to the effect that use of the agent be discontinued if a rash develops or if salivary glands swell.

Antibiotic therapy certainly should be considered if the asthmatic patient becomes febrile, but it is equally important to know why the patient is febrile and the type of bacteria or virus respon-

sible. It also should be remembered that hypersensitivity to drugs may be evidenced by fever.

STEROID THERAPY

Steroid therapy for asthma has been abused and overdone. Too many patients attempt to regulate their own steroid treatment. Too many patients have hypercortisonism in addition to asthma. This situation has resulted in a higher incidence of deaths and morbidity from asthma than was encountered before steroids were added to the drugs used to treat asthma. Short-term (seven to ten days) therapy with steroids may be indicated and justified for the swift control of severe status asthmaticus, and occasionally this treatment may be used to save time in preparing the asthmatic patient for some type of major surgical operation. Long-term therapy with steroids generally should be avoided. Most patients do not understand the complications which may follow long-term steroid therapy, nor have they been warned that, in the face of an impending major stress, such as an operation or operative treatment of a fracture, they need to increase greatly their dosage schedule of steroids to be able to withstand the challenge.

Physicians and patients alike are aware that asthma becomes more severe if steroid treatment is suddenly discontinued, or if withdrawal of steroids proceeds too rapidly. It should be the goal of nearly all patients taking steroids for asthma to discontinue the use of these agents and to depend on safer remedies for the symptomatic treatment of their asthma. This objective can be accomplished if the use of steroids is diminished very gradually, and usually over a period of many months, until none are taken.

If the patient is intelligent and cooperative and has been thoroughly studied, and all contributing causes of asthma, including complications and overcoughing, have been controlled, it is time to begin a program for the discontinuance of steroid therapy. The patient must understand that during withdrawal of the agent he will feel weak and tired, that he may ache and that he may notice some increase in the severity of his asthma. He should be taught to rely on safe, conventional, symptomatic remedies for asthma when symptoms develop.

Once the patient's minimal daily requirement of steroids has been determined, this amount is administered in three or four divided doses daily, and no change in the dose should be made for approximately a month. Thereafter, at monthly intervals, the total daily dose is reduced by a decrement of 1 mg.

It can be seen, then, that a patient whose present minimal daily requirement is 12 mg probably will require 12 months to complete withdrawal. The suppressed adrenal gland resumes its normal function slowly and grudgingly.

The patient should be warned that unanticipated situations of stress may occur during withdrawal of steroids, a cold may intervene, or something else which exerts stress may happen, in which event some temporary increase in the dose of the steroid (large or small, depending on the degree of stress) may be necessary. After a few days or a week of use of a larger dose to meet the stress, the regular program of withdrawal should be resumed. Withdrawal of steroid therapy prescribed for asthma can be accomplished but it cannot be hurried. The greatest difficulty in the withdrawal of steroids arises when the afflicted patient cannot, for economic or social reasons, carry out an adequate program of treatment for asthma, such as has been outlined above.

DANGERS OF ARSENIC THERAPY

The use of arsenic against asthma is the oldest recorded treatment known. It is still in use in certain areas and asthma clinics. Although arsenic is often effective in suppressing the symptoms of asthma, use of this agent is to be avoided because of its many possible toxic side effects. Frequently we have seen keratoses of the hands and feet follow the taking of arsenic; cancers of the skin and damage to the liver may be sequelae of the treatment of asthma with arsenic. Hemorrhagic encephalitis with blindness and microaneurysms in the eye, which bleed whenever the patient with asthma coughs hard—both conditions leading to progressive blindness—have been seen in patients taking arsenic (Fowler's solution) for the relief of asthma. These and other toxic effects are the risks run by taking arsenic to suppress asthma.

TEAM APPROACH TO ASTHMA TREATMENT

It should be obvious from the foregoing that the investigation and treatment of a patient who has asthma should be carried out, not by one person, but by a team of physicians. The team should be headed preferably by an internist interested in asthma and allergic diseases. On the team may be found an allergist, an otolaryngologist, a roentgenologist, a bacteriologist, a bronchoscopist, and others, depending upon the various indications in each case. A psychiatrist is needed on the team only if psychosis is associated with the asthma, which is rare. Asthma in itself of course is not a psychosis, and it should not be necessary to seek psychiatric consultation for asthma alone.

OBJECTIVE—CURE OF ASTHMA

The patient with asthma has only one objective when he consults a physician—he wants to be

cured. The objective of the physician also should be to cure the patient's asthma and not simply to provide temporary symptomatic relief. Asthma can be cured. In taking the histories of patients we often hear the patient say that he had asthma in his youth, but that it disappeared, for one reason or another. Our famous President Theodore Roosevelt, a most vigorous hunter and outdoor man, had severe asthma in childhood and as a young man. At least twice he had to resort to a radical change of environment to overcome the disease, but overcome it he did.

"Unlike Theodore Roosevelt, bronchial asthma struck at Calvin Coolidge when he was older. As a youth he became sensitive to pollens, horse dander, and house dust, and to many foods, among them peanuts which he liked but which almost always made him ill. His eyes would itch and burn, and sneezing, coughing and a running nose were frequent annoyances. His nasal twang was undoubtedly influenced by the allergy. Coolidge had some of his worst allergic experiences when he was Vice-President. The Senate floor at that time was covered by straw matting, an excellent collector of years of house dust."[1]

For obvious reasons, not all patients are able to carry out all the measures necessary for the cure of asthma. In other persons the disease will have progressed to a stage which is irreversible (meaning emphysema), so that it is never appropriate actually to discuss "cure of asthma" with the patient. Nevertheless, cure of asthma is and should be the objective of both the patient and his physician.

No medication cures asthma. All the various medicines used in the treatment of asthma merely relieve symptoms, assist in controlling infection or suppress inflammation; they cure nothing.

Cure of asthma depends upon removal of the causes and complications of asthma, successful avoidance of all respiratory irritants, including overcoughing to raise mucus, and upon putting the inflamed air passages to rest so that they may have the opportunity to heal.

To accomplish a cure it is necessary to have an intelligent and cooperative patient who is able to carry out an adequate program such as has been outlined herein. In this respect the patient often is his own worst enemy. He persists in smoking or breathing occupational dusts which he knows will aggravate his coughing and wheezing and asthma. He usually does not know that overcoughing to raise mucus is one of the worst things he can do if he has asthma. A typical comment of such patients is "Why wasn't I told not to cough so hard? I've been doing everything wrong for years."

Some features of today's treatment of asthma can be expected to be out of date tomorrow. For instance, new knowledge is being gained rapidly about immunologic mechanisms, and this information in time should assist us in the treatment of asthma which is strictly allergic in origin. However, allergy is not the cause of most instances of asthma, and other measures or approaches will be necessary to improve our present treatment of intrinsic asthma. New drugs, new vaccines for colds, and new operations to relieve bronchospasm are being investigated. The problem of asthma is not static.

Optimism is in order, but this is no reason for the patient who has asthma to sit and wait for new discoveries. The present treatment of asthma is sound and more nearly adequate than many patients and physicians realize. We cannot overemphasize, however, the fact that no matter what new treatments for asthma may evolve, we shall always be confronted with the treatment of the bronchitis which is an integral part of all asthma; bronchitis will always require rest for healing, after the causes of asthma and the complications of asthma have been removed or have been adequately treated and after the associated cough has been controlled. Ignoring this fundamental truth accounts for many disappointments in the treatment of asthma. ■

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It's Only Money!
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Ear surgery is effective in many cases of deafness, and should be considered in all. Here's how to select cases.

Rehabilitation of the Hearing Handicapped

R. BRUCE JOSEPH, M.D., *Honolulu*

• *Hearing is important. Sudden deafness is four times as likely to result in suicide as sudden blindness. In conductive deafness, stapedectomy, myringoplasty, or tympanoplasty offer an 80 to 90 per cent likelihood of restoration of hearing to a useful degree.*

ADEQUATE service to the patient with impaired hearing is the physician's obligation. Hearing competes with sight as the most important of the five senses. The incidence of suicides among persons who have suddenly become deaf is four times that of those suddenly blinded.[1] Certainly in an age when communication is of ever increasing importance, actual or even threatened hearing loss preoccupies many patients. The following article is a review of the established hearing tests and recent advances in surgery to restore hearing.

NERVE VS. CONDUCTIVE DEAFNESS

Distinction between sensory-neural (nerve or perceptive) hearing loss and conductive hearing loss is especially important. A typical audiogram from a patient with a sensory-neural hearing loss is illustrated in Fig. 1. The zero line represents normal hearing. Note that pure tone thresholds are depressed equally for both air and bone conduction. Although this ear retains some hearing (Fig. 1), loud speech three feet away would be barely audible. The patient with the sensory-neural hearing loss not only has impaired hearing, but often has impaired discrimination or understanding as well. Even though speech is amplified well above his threshold, it may still be unintelligible due to his poor discrimination. Because of impaired discrimination, patients with a sensory-neural hearing loss have more difficulty using a hearing aid than do those patients with conductive losses. Recruitment, which is a phenomenon associated with certain types of sensory-neural hearing loss, renders the ear intolerant of loud sounds and creates problems in hearing-aid fitting.

The most common causes of sensory-neural loss in the adult are the following:

1. Presbycusis: hearing loss associated with age.
2. Acoustic trauma: hearing loss due to excessive noise exposure such as jet engines, air hammers, firearms, etc.
3. Menière's disease or endolymphatic hydrops: a disease of unknown etiology characterized by recurrent episodes of vertigo and a fluctuant, progressive hearing loss.

Most sensory-neural losses in children are due to the following:

1. Congenital: this term includes deafness due to maternal virus illnesses in the first trimester (e.g.,

Received for publication, January 31, 1963.

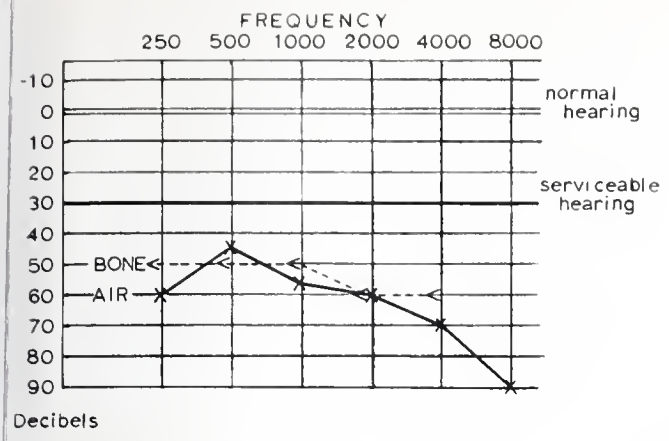


FIG. 1.—*Audiogram depicting a moderately severe, sensory-neural hearing loss involving the left ear. Right ear thresholds are not shown.*

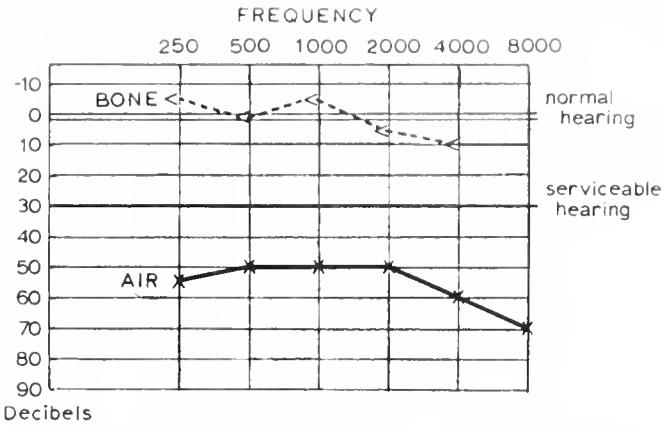


FIG. 2.—*Audiogram depicting a conductive hearing loss involving the left ear. (50 decibel air-bone gap).*

rubella), as well as idiopathic developmental anomalies of the cochlea.
2. Hereditary: hereditary sensory-neural deafness may be manifest at birth and thereby "congenital," but often the deafness begins in childhood and is progressive.
3. Ototoxic drugs: the following drugs can cause sensory-neural deafness in children and adults: streptomycin, dihydrostreptomycin, kanamycin, neomycin, and vancomycin.[2]

Conductive hearing losses are those in which sound conduction through the external and middle ear to the cochlea is impaired. Pure tone thresholds for air conduction are depressed while bone conduction remains normal (Fig. 2). Most conductive losses in adults are due to fixation of the stapes by otosclerosis or damage to the ear drum and ossicles from chronic otitis media. The most common causes of conductive losses in children are:

1. Chronic serous otitis media due to poor eustachian tube function which, in turn, is often caused by enlarged adenoids.
2. Chronic suppurative otitis media.
3. Congenital anomalies of the external or middle ear.

Impacted wax in the ear canals is a common cause of conductive hearing loss in both children and adults.

SIMPLE TESTS

Distinguishing conductive from sensory-neural hearing losses can usually be done quickly and easily with a tuning fork. The Weber and Rinne tests are the most useful tuning fork tests. The Weber test is performed by applying the activated fork to the patient's forehead or vertex and noting to which ear the patient lateralizes the sound. Although there are exceptions, the patient with a sensory-neural loss will lateralize to the better hearing ear. The patient with a conductive loss will lateralize to the worse ear. This test is most useful in unilateral losses.

The Rinne test is performed by alternately testing the patient's air and bone conduction. The fork should be activated by the examiner's usual uniform method and should be placed alternately on the mastoid and alongside the ear. When testing the hearing by air, the prongs of the fork should be held in line with and about one inch away from the external auditory meatus.[3] The patient with a conductive loss will hear the tone louder with the fork against the mastoid (bone conduction). When the sound is heard louder by bone conduction, the Rinne test is said to be negative. This is somewhat confusing in that normal ears, and also ears with a sensory-neural loss, test positive. Because of this confusing terminology, test results are often abbreviated BC>AC when the Rinne test is negative and AC>BC when the test is positive.

In a unilateral sensory-neural loss, a false negative Rinne (BC>AC) may be obtained when the deafened ear is tested, unless a masking noise is applied to the good ear. The bone conduction stimulus (tuning fork applied to the mastoid) crosses the skull and is heard in the good ear at almost normal threshold. A convenient masking noise may be produced by rubbing the tragus of the good ear while performing the Rinne test on the opposite ear.

The 512 fork is recommended for the Weber and Rinne tests. The vibrations of the 128 and 256 forks may be felt rather than heard. The higher pitched forks may be heard too well by air conduction.[4]

Many conductive hearing losses are now surgically remediable, hence the great importance in distinguishing them from sensory-neural losses. The cause of the conductive hearing loss can usually be determined by otoscopy. Of unilateral conductive losses with normal ear drums, 90 per cent are due to otosclerosis.[5] Nearly all patients with a bilateral conductive loss and normal ear drums have otosclerosis.

AUDIOMETRY

In order to determine the exact degree and type of hearing loss present, pure tone and speech audiometry are available. Pure tone audiometric

DATE		RIGHT EAR						LEFT EAR					
		250	500	1M	2M	4M	8M	250	500	1M	2M	4M	8M
5-7-61 (pre-op)	BC	0	-5	0	5	10		-5	0	-5	5	10	
	AC	40	30	35	40	50	55	55	50	50	50	60	70
7-7-61 (post-op)	BC												
	AC	40	30	35	40	60	55	0	5	0	5	10	30
	BC												
	AC												

TABLE 1.—*Audiogram in the form of a table permitting serial recordings and easy comparison.*

testing is recorded as an audiogram (Figs. 1 and 2) or simply as a table (Table 1). The audiogram depicts graphically the type and degree of hearing loss. The table is advantageous in that serial audiometric tests can be recorded on the same sheet of paper permitting the examiner to compare one hearing test to others taken at a later date. In the audiogram, the zero line represents normal hearing, and the lines below indicate the decibel hearing loss for the particular frequency tested. Most hearing centers test only the six frequencies shown (i.e., 250, 500, 1000, 2000, 4000, and 8000 cycles per second). These are called pure tones, since no harmonics or overtones are produced by the electronic audiometer; hence the term "pure tone audiometry."

"Air-bone gap" is a term commonly used in describing conductive and mixed hearing losses. The air-bone gap represents the decibel difference between the thresholds for bone and air conduction. It is usually restricted to the average decibel difference between air and bone conduction for the speech frequencies (500, 1000, and 2000 cycles per second). Fig. 2 represents a patient with an average 50 decibel air-bone gap in the left ear. Results of otologic surgery are evaluated by the degree of air-bone gap closure achieved.

The three frequencies—500, 1000, and 2000 cycles/second—are called the speech frequencies, since they represent the approximate frequency range of the spoken voice. Good hearing for the higher frequencies is less important, since it is not essential for understanding speech.

Speech audiometry is a further advance in hearing testing. It is indispensable for the proper trial and fitting of hearing aids, but in addition can furnish valuable information about the patient's hearing ability. Two tests are routinely made with the speech audiometer. The first is called the speech reception threshold (SRT) and determines the patient's threshold of hearing for simple speech sounds. The second is called the discrimination test and ascertains the patient's ability to discriminate between various speech sounds. The testing material used for determining the speech reception threshold is a list of bisyllabic words with equal emphasis on each syllable; such words are called spondees (e.g., railroad, baseball, airplane, etc.). These are played through a set of earphones worn by the patient, and the threshold for each ear is determined.

The accepted threshold for speech is that intensity level at which 50 per cent of the spondee words are heard correctly. For normal ears this is, of course, the normal threshold for speech, and is the zero reference level (abbreviated SRT=0). For ears with impaired hearing, the threshold for speech is that level of intensity which has been used to amplify the sound of the spondee words so that 50 per cent of them have been correctly understood. The speech reception threshold should correspond very closely to the average threshold for the speech frequencies as determined by pure tone audiometry.

Testing material for determining speech discrimination is not the same as that used for obtaining the speech reception threshold. Speech discrimination testing is done with lists of 50 monosyllabic words; each list contains a sufficient variety of words to include most of the sounds in the English language. These word lists are known as phonetically balanced or PB lists (e.g., are, bad, bar, bask, box, cane, etc.).

The routine speech discrimination test is done by testing an ear with a PB list of 50 words at 30 decibels above the speech reception threshold of that ear. At this intensity the patient can "hear" the words, but he must be able to "discriminate" between similar sounds and repeat the words correctly. The number of words heard correctly in each 50-word list is multiplied by two, to determine the per cent discrimination score.

In general, patients with sensory-neural deafness have poor discrimination scores (below 90 per cent) while patients with a conductive loss approach normal discrimination scores (90-100 per

cent). The poor discrimination associated with sensory-neural deafness is the principal reason for difficulty in using a hearing aid. "I can hear the sounds, but can't understand the words," is a common statement made by patients with a sensory-neural loss. The discrimination test not only helps determine the type of deafness, but also furnishes valuable information regarding the patient's suitability for a stapedectomy. Many patients with otosclerosis have a mixed deafness and may have poor discrimination. If the discrimination score is low, the patient will usually have persistent difficulty understanding speech postoperatively, even though his pure tone and speech reception thresholds have been improved considerably.

"RECRUITMENT"

Recruitment may be defined as a phenomenon associated with certain types of hearing losses in which the loudness of tones appears to increase more rapidly than normal, with given increments of sound intensity. For example a tone presented 40 decibels above the threshold of a recruiting ear will be uncomfortably loud. A tone of the same frequency presented to a normal ear 40 decibels above threshold will not seem loud at all. If a person has one normal-hearing ear and a 50-decibel loss in the opposite ear, one would suppose that a 20-decibel stimulus to the normal ear and a 70-decibel stimulus in the deafened ear would seem equally loud. And so they do, unless recruitment is present.

If the deafened ear shows recruitment, a 70-decibel stimulus may seem equally loud to each ear (70 decibels above threshold for the normal ear, but only 20 decibels above threshold for the recruiting ear). A recruiting ear can detect intensity increments as small as one decibel, while most normal ears cannot.[5]

Several audiometric tests are used to measure recruitment. Recruitment is often present when there is pathology involving the cochlear hair cells as in Menière's disease, but absent in lesions of the acoustic nerve such as acoustic neuroma. Thus recruitment tests help to localize the site of pathology in cases of sensory-neural deafness.

MANAGEMENT OF SENSORY-NEURAL HEARING LOSS

Intensive vasodilator regimens are thought to benefit Menière's disease[6] and idiopathic sensory-neural losses of sudden onset. Adequately controlled studies of this therapy are still lacking. At the present time there is no proof that any drug or surgical procedure will improve hearing in sensory-neural deafness. Many operations have been devised to eliminate the recurring episodes of vertigo in Menière's disease. Most of these operations also sacrifice hearing in the ear operated upon, and are only indicated on patients with severe unilateral involvement. Selective destruction of the vestibular labyrinth with ultrasound has been used with varying results.[7,8] Decompression of the endolymphatic system by a shunt from the saccus endolymphaticus to the subarachnoid space has been done recently with some success.[9]

Most individuals with an average loss of 30 decibels or more for the speech frequencies obtain valuable assistance from hearing aids. Hearing better than the 30-decibel level is often referred to as "serviceable hearing," since the patient can get along fairly well without a hearing aid.

Unfortunately, patients with sensory-neural losses have more difficulty using a hearing aid than do patients with conductive losses. Among the factors which contribute to this difficulty are the following: recruitment, poor discrimination, and extremely severe losses (pure conductive losses never exceed 60 decibels). Nevertheless, many nerve-deaf patients do obtain gratifying results with amplification; therefore, audiometric testing to determine their suitability for a hearing aid should be done in every case. Often lessons in speech reading and auditory training in addition to amplification are required to rehabilitate the patient with a severe sensory-neural loss.

TREATMENT OF CONDUCTIVE LOSS DUE TO OTOSCLEROSIS

Otosclerosis accounts for most cases of progressive conductive hearing loss in adult life.[10] It is a primary focal disease involving the temporal bone. It may cause a sensory-neural loss by involvement of the cochlea, but usually is asymptomatic unless the otosclerotic focus involves the stapes. Otosclerotic invasion of the stapes interferes with stapedial motion and causes a conductive hearing loss. Guild sectioned human temporal bones and found histologic evidence of otosclerosis in 9.7 per cent of white men and 18.7 per cent of white women between the ages of 30 and 50.[11] It is less common in Orientals. Only about one in eight patients with histologic otosclerosis have involvement and fixation of the stapes causing a conductive hearing loss.

At the present time most otologists consider stapedectomy the treatment of choice for hearing loss due to otosclerosis. Because of cochlear damage some patients with otosclerosis cannot be helped by surgery. Associated sensory-neural loss may render discrimination so poor that stapedectomy is contraindicated.

Stapedectomy may be done under local or general anesthesia. Magnification with a binocular operating microscope is essential. A small tympa-

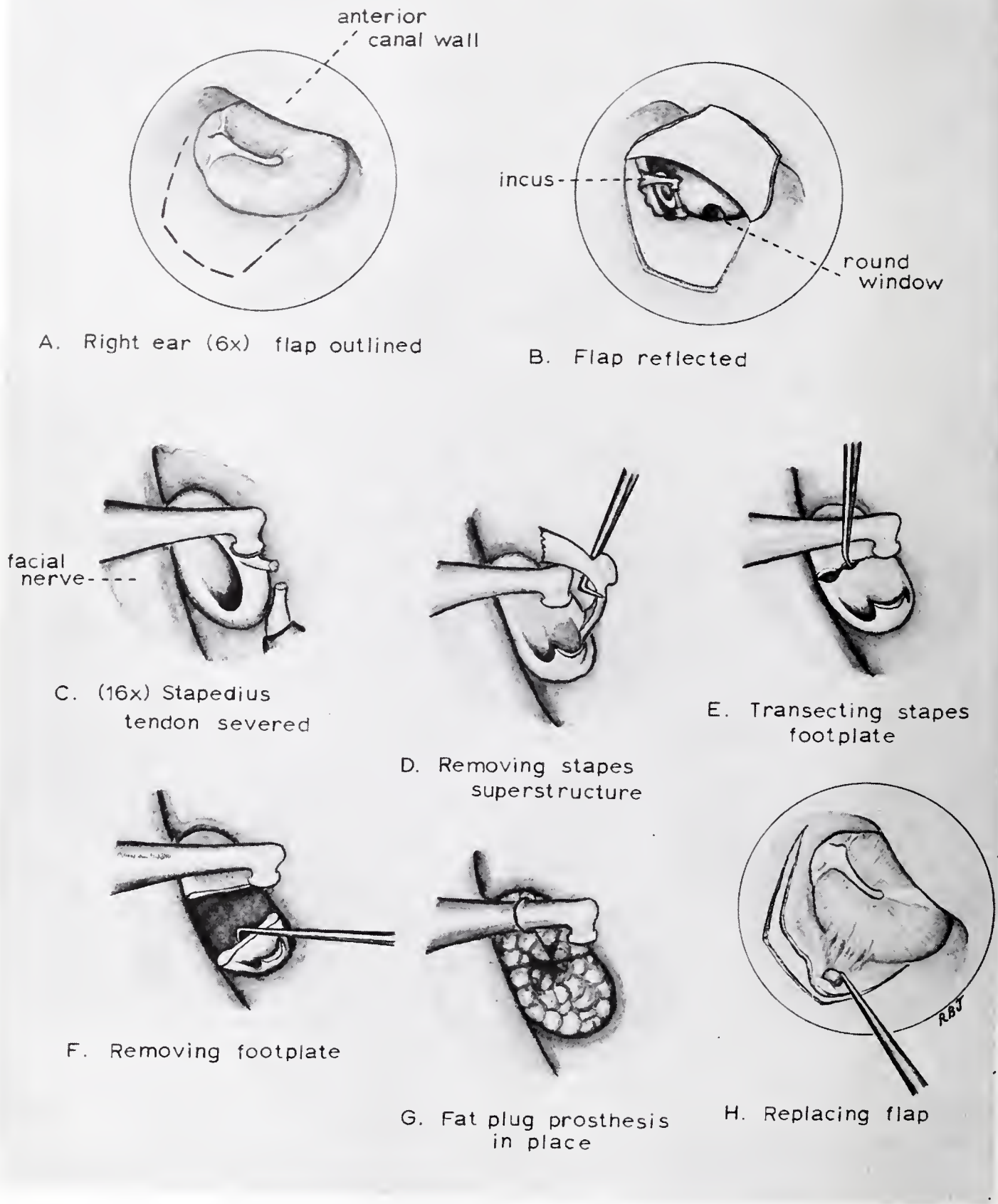


FIG. 3.—*Stapedectomy performed on the right ear as seen through the operating microscope at 6X and 16X magnification. A. The tympanomeatal flap is outlined. B. The flap has been cut and elevated exposing the incus and stapes. C. The stapedius tendon has been cut as the first step in removing the stapes. D. The incudostapedial joint has been disarticulated. The stapes superstructure has been fractured from the stapes footplate and is being removed. E. The footplate is being transected by multiple small fenestrations. F. The posterior one-half of the footplate is being removed. The anterior one-half will be removed in like manner. G. The fat plug prosthesis has been placed in the oval window, and the wire crimped around the long process of the incus. H. Flap being replaced in its original position.*

nomeatal flap is cut and elevated as shown in Fig. 3 (A and B). A prosthesis of stainless steel wire and ear lobe fat is then used to replace the stapes (Fig. 3, C-G).

Other methods of stapedectomy differ chiefly in the material used in constructing the prosthesis —polyethylene and Teflon instead of wire; vein or Gelfoam instead of fat.

The patient may experience some vertigo postoperatively, but is usually able to leave the hospital the next day and return to work two to three days after surgery. Hearing improvement begins about two weeks, and is maximum about four months, after surgery.

In evaluating the hearing results of stapedectomy, the term air-bone gap closure is often used. As mentioned previously, the air-bone gap is usually defined as the average air conduction threshold minus the average bone conduction threshold for the speech frequencies. Thus the audiogram shown in Fig. 2 represents an air-bone gap of 50 decibels. (Average air conduction for 500, 1,000, and 2,000 cycles equals 50 decibels, while the average bone conduction for these speech frequencies equals zero). Air-bone gap closure is achieved if postoperative air conduction is brought up to the level of preoperative bone conduction for the speech frequencies.

Most stapedectomy results are now reported as per cent air-bone gap closures within 10 decibels: in other words, the percentage of ears operated upon which achieve a postoperative air conduction level within 10 decibels of pre-operative bone conduction. The level of pre-operative bone conduction is the theoretical maximum hearing that can be achieved since bone conduction represents the ear's cochlear reserve. If the pre-operative bone conduction is zero or normal, the patient has a normal cochlea and eighth nerve, and can expect normal hearing postoperatively.

Many patients with otosclerosis have a mixed hearing loss, i.e., a conductive loss with a sensory-neural component. A patient may have a 25 decibel bone conduction and a 70 decibel air conduction level for the speech frequencies (Fig. 4). Such a patient can achieve serviceable hearing, but not normal hearing, provided that he attains the maximum hearing gain.

Stapedectomy has a high success rate: from 75 to 94 per cent of cases achieve air-bone gap closure within 10 decibels.[12-15] Of the remaining patients, one or two per cent develop a further loss of hearing, two to four per cent remain unchanged, while the rest show a significant hearing gain—10 decibels or greater—but fail to close the air-bone gap.

In my series of 42 stapedectomies, 38 (90 per cent) achieved air-bone gap closure within 10

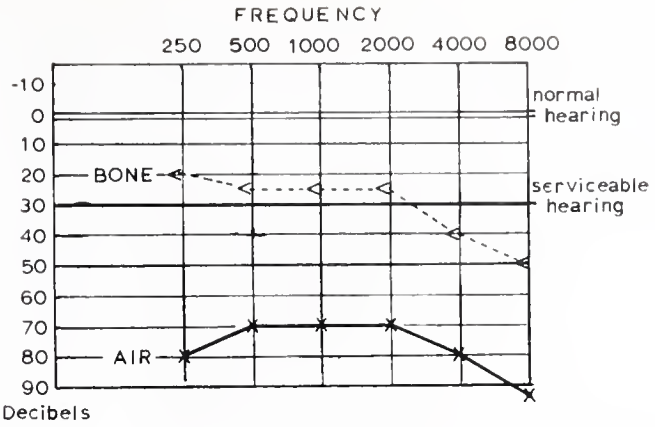


FIG. 4.—*Audiogram which shows a mixed hearing loss (45 db air-bone gap).*

decibels. Four patients (10 per cent) achieved significant hearing improvement (10 decibels or better for the speech frequencies), but failed to close their air-bone gap. The fact that no patients suffered further hearing loss must be attributed to the small size of the series. Most large series show a one to two per cent incidence of ears made worse by surgery, and patients must be warned of this possibility. Because of this small but definite incidence of increased hearing loss following surgery, the worse ear is always operated on first. Only after the worse ear has been converted by surgery to the better hearing ear, and has remained so for six months, should the opposite ear be operated upon.

TREATMENT OF CONDUCTIVE LOSS DUE TO CHRONIC OTITIS MEDIA

Myringoplasty

Hearing loss due to chronic otitis media results from ear drum perforations and disruption or fixation of the ossicular chain. If only the ear drum has been damaged, myringoplasty is the surgical procedure performed to improve hearing. If there has been damage to the middle ear ossicles, some type of tympanoplasty must be done.

Contraindications to myringoplasty are the following:

1. Infected, draining ears. Draining ears must be Treated with local or systemic antibiotics or both until the ear is "clean and dry." The ear must then demonstrate its ability to stay dry for at least two months prior to surgery. If a dry ear cannot be achieved by conservative methods, then a surgical procedure more extensive than a myringoplasty must be performed.
2. Poor eustachian tube function. Good eustachian tube function is required to provide an air-containing middle ear space, which is essential for good hearing.
3. Marginal and *pars flaccida* perforations. These types of perforations are usually associated with cholesteatoma or active bone infection. Simply repairing the perforation would risk covering up active disease. Perforations that are suitable for myringoplasty repair must be central in type; i.e., a rim of drum remaining around the perforation.

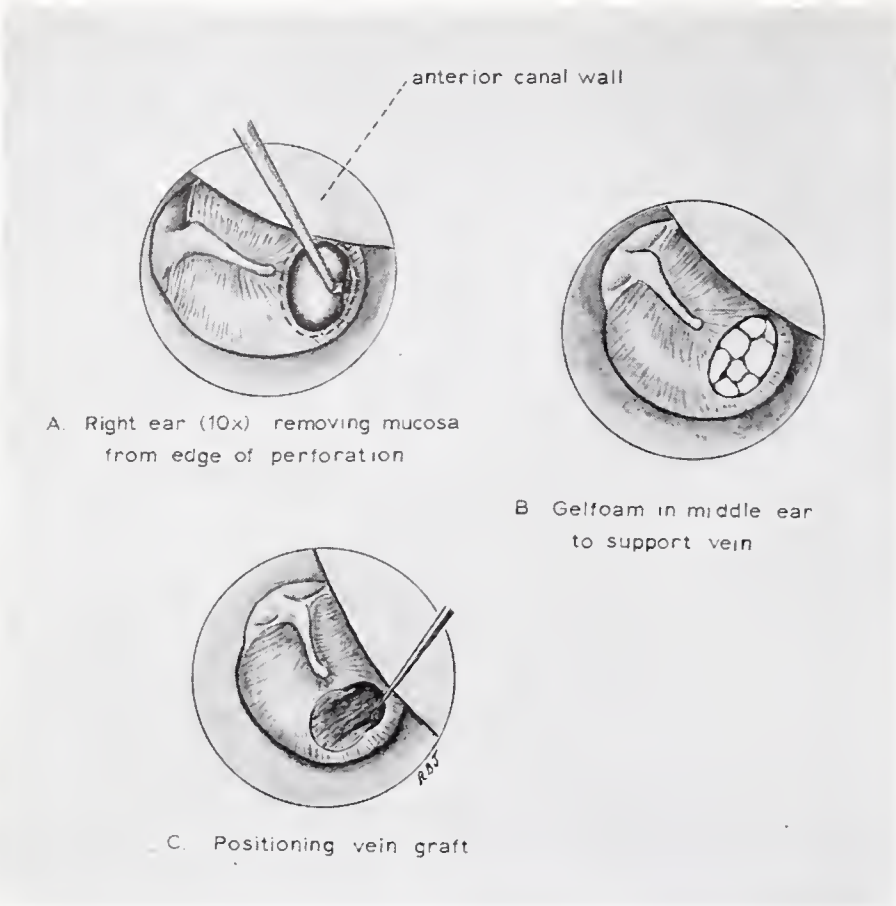


FIG. 5.—*Vein graft myringoplasty on the right ear.*

A. The under surface of the ear drum is being denuded of mucosa two millimeters around the perforation edge to provide a raw surface for the vein graft.

B. Pledgets of Gelfoam have been placed in the middle ear to provide support for the vein graft.

C. With the intima toward the middle ear, the edges of the vein are being tucked under the perforation edge. The ear canal will be packed with pledgets of Gelfoam, thus stabilizing the vein graft.

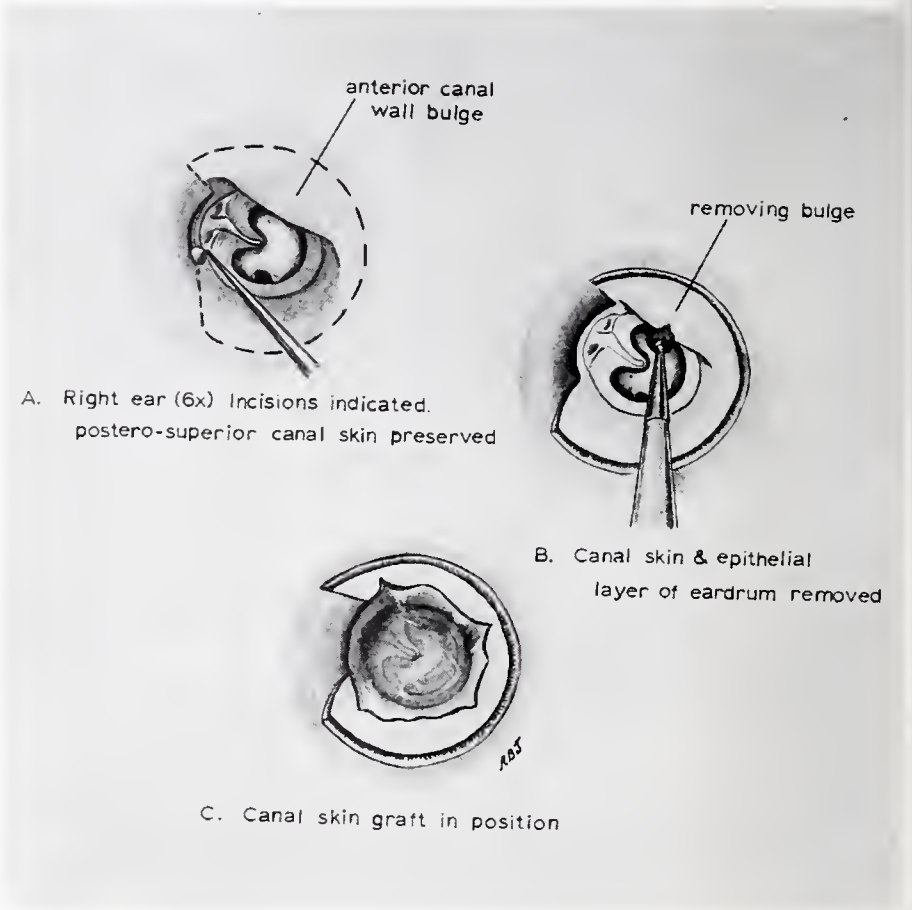


FIG. 6.—*Canal skin myringoplasty, right ear.*

A. The incision above the pars flaccida has been started. Remaining incisions are indicated by the dotted lines. Note that the postero-superior canal skin ("vascular strip") is preserved to prevent stenosis of the ear canal and to help revascularize the skin graft.

B. The canal skin graft and epithelial layer of the ear drum have been removed. The anterior canal wall bulge is being removed with a motor driven bur in order to visualize the anterior portion of the ear drum.

C. The canal skin graft has been positioned over the ear drum remnant. Note edge to edge approximation of the graft with the vascular strip. Gelfoam packing will be used to stabilize the graft and fill the ear canal.

4. Better hearing ear. If the patient has a bilateral hearing impairment from whatever cause, any surgical procedure done primarily to improve hearing on the better hearing ear is contraindicated. Further loss of hearing following a myringoplasty is much less frequent than even the one to two per cent incidence following stapedectomy. This risk is nonetheless present and contraindicates myringoplasty on the patient's better hearing ear. Active infection or cholesteatoma, which threatens to increase hearing loss or to produce intracranial complications, may necessitate mastoid surgery on the better hearing ear to preserve life and hearing. A guiding aphorism is "Never operate for hearing on the better-hearing ear."[16]

Although myringoplasty techniques vary, most otologists now utilize either external auditory canal skin or vein as autogenous graft material to repair the perforated ear drum. I use vein for perforations involving one-third the area of the ear drum or less, and canal skin for larger perforations. These procedures are illustrated in Figures 5 and 6.

Myringoplasty serves two purposes: (1) to improve hearing by increasing the effective vibrating area of the tympanic membrane; and (2) to seal the middle ear area from external contamination (especially important in Hawaii, where swimming is popular). A completely succesful myringoplasty would include a restored ear drum and improved hearing, although either would constitute a partial success.

In my series of 19 myringoplasties, 16 patients (84 per cent) achieved intact ear drums and significant hearing improvement. One patient with a total perforation was left with a small residual perforation, but achieved marked hearing improvement (air-bone gap closure). Thus 17 patients (89 per cent) obtained significantly improved hearing. Fifteen patients (79 per cent) closed their air-bone gaps within 10 decibels. The two failures were left with no change in hearing and a residual perforation postoperatively. Subsequently revision myringoplasty on one of these patients achieved an intact eardrum and air-bone gap closure. The other failure has been lost to follow-up.

Mastoid and Tympanoplasty Surgery

Complete eradication of cholesteatoma and irreversibly diseased tissue must be included in any tympanoplasty or mastoid operation. This long-known and almost self-evident fact was sometimes neglected in the original wave of enthusiasm for tympanoplastic surgery. Many tympanoplasties are combined with mastoidectomy to remove cholesteatoma and infected or necrotic tissue. In some cases surgery must be done in two stages; i.e., a preliminary mastoidectomy to eliminate active disease and achieve a dry ear, followed by tympanoplasty to restore hearing. There are still many instances when either no surgery, or some form of mastoidectomy without tympanoplasty, is indicated. Discussion of the many indications for and contraindications to mastoid and tympanoplastic procedures is beyond the scope of this paper.

The purpose of a tympanoplasty is to eradicate disease, to improve hearing, and to seal the middle ear and mastoid from external contamination. In the normal ear, vibrations of the ear drum are transmitted through the ossicular chain to the cochlea. The pressure of sound waves transmitted to the cochlea is augmented about 22 times by the transformer action of the tympanic membrane and ossicular chain. This pressure increase of 22 times equals 27 decibels according to the equation, $Db = 20 \log 22$. Most of this pressure differential is due to the marked difference in area between the large ear drum (55 mm^2) and small footplate (3.2 mm^2). This areal ratio of 55/3.2 equals 17 and is equivalent to 24.5 decibels. The ossicular chain serves primarily to transmit the vibrations, but also augments sound pressure by a factor of 1.3 (2.5 decibels).[10]

Other factors affecting the efficiency of the middle ear transformer mechanism are the following: stiffness and mass of the ossicular chain, resistance or friction impeding its vibrations, and degree of round-window protection from the sound waves.

Restoration of the tympanic membrane has been discussed under myringoplasty. These same techniques are used to repair the ear drum in a tympanoplasty. If parts of the ossicular chain are fixed or missing, transmission of the ear drum's vibrations can be accomplished by the following:

1. The ear drum can be placed in contact with the stapes capitulum provided that the stapes is intact and mobile.
2. By using a prosthesis constructed of stainless steel wire or other nonreactive substances to connect the malleus or ear drum to the stapes.

Both of these methods create the columella effect analogous to the single ossicle found in birds' ears. Since the lever action of the ossicular chain provides only 2.5 decibels hearing advantage, the ossicular chain can be replaced by these mechanisms with little compromise to hearing improvement. The abnormalities found during tympanoplastic surgery are many and varied, as are the methods of dealing with them. Most techniques, however, are modifications of the methods cited above.

Because of marked variation in the extent of middle car damage, the prognosis for hearing improvement varies widely among tympanoplasty candidates. Factors which diminish the chances for a favorable hearing result are the following:

1. Thickened, infected middle ear mucosa.
2. Active infection refractory to conservative treatment.

3. Very large or "total" perforations.
4. Absence of the malleus.
5. Absence of the stapes superstructure.
6. Fixation of the stapes.

The aims of tympanoplasty in the order of their importance are the following:

1. A "safe," dry ear.
2. Improved hearing.
3. A restored ear drum which effectively seals the middle ear and mastoid from external contamination.

In general hearing gains from tympanoplasties are less impressive than stapedectomy and myringoplasty results. Air-bone gap closures within 10 decibels are exceptional following tympanoplasties. Most myringoplasty candidates have serviceable or near serviceable hearing, whereas the hearing of most tympanoplasty candidates is substantially below the 30-decibel level. Therefore hearing improved to the serviceable level (i.e., 30-decibel average for the speech frequencies, or better) is considered a successful result. In the author's series of 16 tympanoplasties, 63 per cent achieved serviceable hearing and 75 per cent had intact ear drums postoperatively. Either serviceable hearing or an intact ear drum was achieved in 81 per cent while 56 per cent benefited from both. No patient had worse hearing postoperatively, and all ears were dry two months after surgery.

SUMMARY

Sensory-neural and conductive hearing losses are discussed. The tuning fork tests used to distinguish these types of hearing loss are described.

The diagnostic and prognostic value of audiometric testing is discussed. The phenomenon of recruitment is defined.

The management of the sensory-neural loss is reviewed.

The surgical management of conductive hearing loss is discussed. Stapedectomy is described and illustrated.

The two principal methods of myringoplasty are described and illustrated. The author's myringoplasty results are cited.

Tympanoplasty is discussed regarding its physiologic basis, inherent problems, and the author's results. ■

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Criticism of Drug Advertisements

If . . . the doctor, when he comes across an ad he doesn't like, would take the time to write, to the drug house responsible, a letter or even a postal card indicating his objections, the results would surprise him. As far as the physician is concerned, the pharmaceutical industry is much like Sweet Alice in the poem "Ben Bolt." As you remember, she "wept with delight when you gave her a smile and trembled with fear at your frown." At SK&F, when we get a critical letter from a doctor, we really turn the place upside down.—Francis Boyer, Chairman of the Board, Smith Kline & French Laboratories, in New York Academy of Medicine *Bulletin,* March, 1962.

A fatal case of leptospiral myocarditis due to Leptospira pomona, the second ever reported, occurred in Hawaii in 1960.

Myocarditis and Heart Failure Due to Leptospira Pomona

CAPTAIN MARTIN L. NUSYNOWITZ, MC, USA,* *Honolulu*

• *An account is given of a patient manifesting congestive heart failure which proved to be due to Leptospira pomona myocarditis, as established by serologic and bacteriologic evidence.*

Prominent symptoms of leptospiral myocarditis are dyspnea, orthopnea, and chest pain; signs include pericardial friction rub, hypotension, arrhythmias, features of congestive heart failure, and extreme digitalis sensitivity. Electrocardiographic features are nonspecific.

Myocarditis is more common in leptospirosis than is generally recognized. A wider knowledge of the clinical manifestations of this disease would probably lead to its more frequent diagnosis.

ALTHOUGH myocarditis as a complication of Weil's disease (leptospirosis due to Leptospira icterohemorrhagiae) is well-known from a pathological viewpoint,[1,2,3] the signs and symptoms are not prominent in the usual case. Gsell[4] described the clinical manifestations of myocardial damage as only a minor feature of leptospirosis.

As far as I could determine, only one case of myocarditis due to L. pomona has been reported in English. In 1953, Sutliff, Shepard, and Dunham[5] reported a case of acute arthritis and myocarditis associated with specific serologic reactions of L. pomona. The myocarditis was characterized clinically by precordial distress, enlargement of the cardiac silhouette, electrocardiographic changes, pulmonary congestion, and respiratory distress.

The following case is believed to be the second report of myocarditis due to L. pomona and the first case in which pathological findings are described.

CASE REPORT

A 71-year-old Japanese man was admitted to Tripler General Hospital, Oahu, Hawaii, on 21 April 1960, with chief complaints of ankle swelling and abdominal distention. One week before admission he had noted anorexia, loss of taste for cigarettes, bilateral ankle swelling, and abdominal protuberance. He denied nocturnal dyspnea, orthopnea, chest pain, or prior episodes of swelling. He had been known to have a positive serologic test for syphilis for over 20 years. System review was otherwise negative. No history of exposure to possible sources of leptospirae was elicited.

Physical examination on admission showed that the temperature was 97° F, the pulse was 160 and irregular, the blood pressure 160/100, and the respirations 22. He was alert and cooperative and

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Received for publication October 2, 1962.

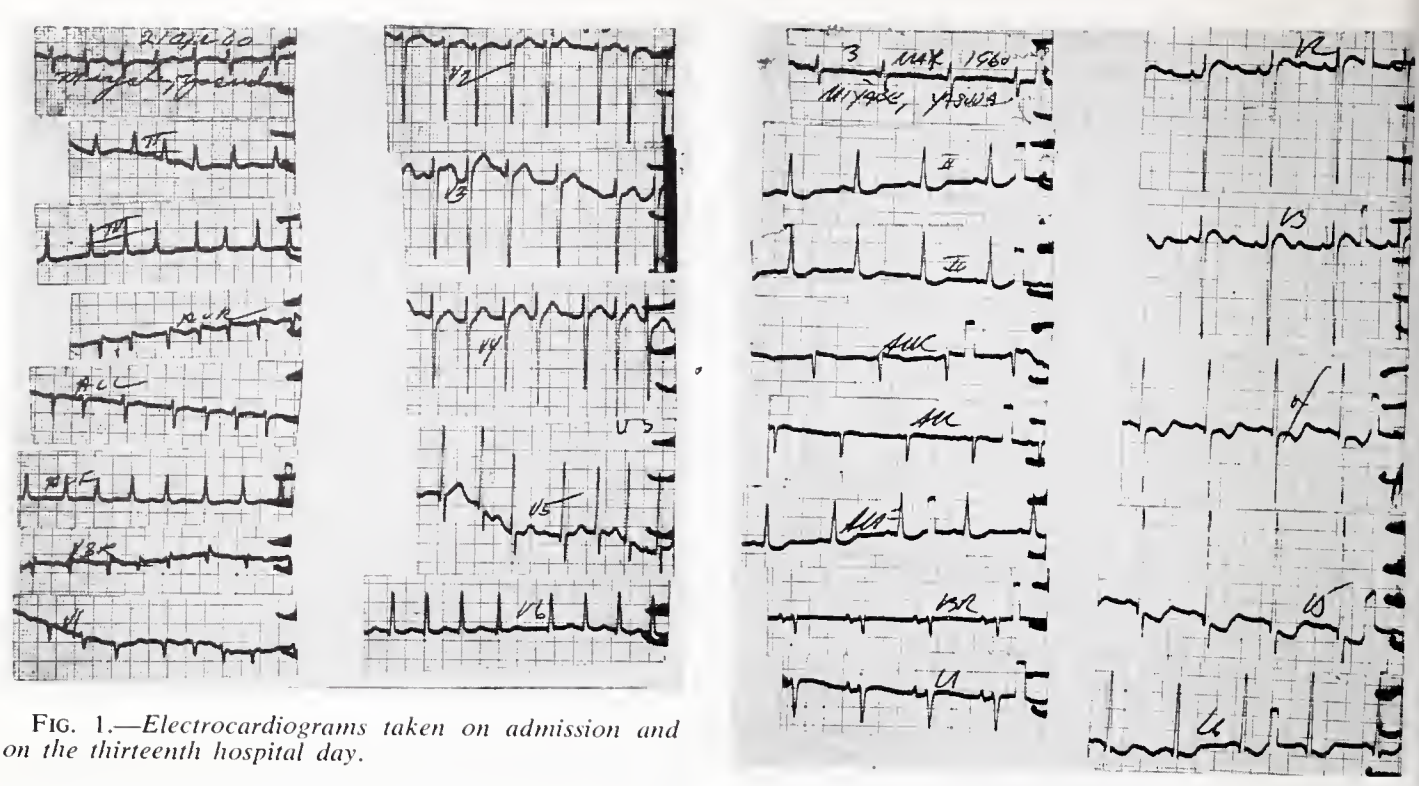


FIG. 1.—*Electrocardiograms taken on admission and on the thirteenth hospital day.*

not in acute distress. Examination disclosed normal sclerae, conjunctivae, and ocular fundi. The neck was supple. There were distended neck veins which filled from below with the patient erect, and hepatojugular reflux was present. The left border of cardiac dullness was displaced laterally. A systolic murmur was present at the apex and along the left sternal border. A dull percussion note and absent breath sounds were noted in the right lower lung field and in Grocco's triangle. A tender liver was palpated 3.5 cm below the costal margin. There was pitting edema of the feet and pretibial regions. Venous pressure was 30 cm of saline; arm to tongue (decholin) circulation time was 19 seconds.

Laboratory data: White blood cell count was 7,500 per cu mm with 72% neutrophiles. Hematocrit was 45% and sedimentation rate was 10 mm per hour (Wintrobe). Urinalysis revealed specific gravity of 1.020, 2+ albumin, 18-20 white blood cells per high power field, and occasional finely granular casts. Blood urea, nitrogen, sodium, potassium, bicarbonate, chloride, and serum total protein and albumin were abnormal. Cardiolipin and complement fixation tests for syphilis were positive.

On the fifth hospital day, total serum bilirubin was 7.9 mg per 100 ml with 3.5 mg per 100 ml direct. Prothrombin activity was 50% and PBI 7.7 mcg per 100 ml. Pleural fluid contained 400 white cells and 5,300 red cells per cu mm. Specific gravity was 1.009, protein concentration was 1.9 gm per 100 ml, and there was no growth on culture. On the eighth hospital day, the cephalin flocculation test was 4+, thymol turbidity was 2.8 units, alkaline phosphatase was 1.9 Sigma units. The white blood cell count was 11,900 per cu mm with 92% neutrophiles.

Cerebrospinal fluid examination on the ninth day revealed no cells and normal sugar and protein levels. On the twelfth day the white blood cell count was 19,400 per cu mm with 89% neutrophiles. Urinalysis showed 4+ albumin, 30-35 white blood cells, and 40-45 red blood cells. Prothrombin activity was 25%, total serum bilirubin was 5.5 mg per 100 ml and serum glutamic oxalic transaminase was 95 units. Total protein had fallen to 4.4 gm per 100 ml with an albumin-globulin ratio of 0.7. A leptospira complement fixation test performed on the thirteenth hospital day (eight days after the onset of jaundice) was positive in a dilution of 1:2 for L. pomona and negative for L. icterohemorrhagiae and L. grippotyphosa.

Chest film on admission showed considerable right-sided pleural effusion with displacement of an enlarged heart to the left. There was no evidence of pulmonary congestion. After thoracentesis the cardiac-thoracic ratio was 15/26.

Electrocardiogram on admission showed right axis deviation, atrial fibrillation with a rate of 160, and flattened T waves in a Ve, a Vf, and V6. The next day frequent unifocal premature ventricular contractions, ST segment straightening and depression, and increased T wave flattening and inversion were noted. On the third day bigeminal rhythm was present. On the thirteenth day the electrocardiogram showed sinus rhythm, left ventricular enlargement, and ST depression and T wave inversion (Fig. 1).

Hospital Course: On admission the patient was

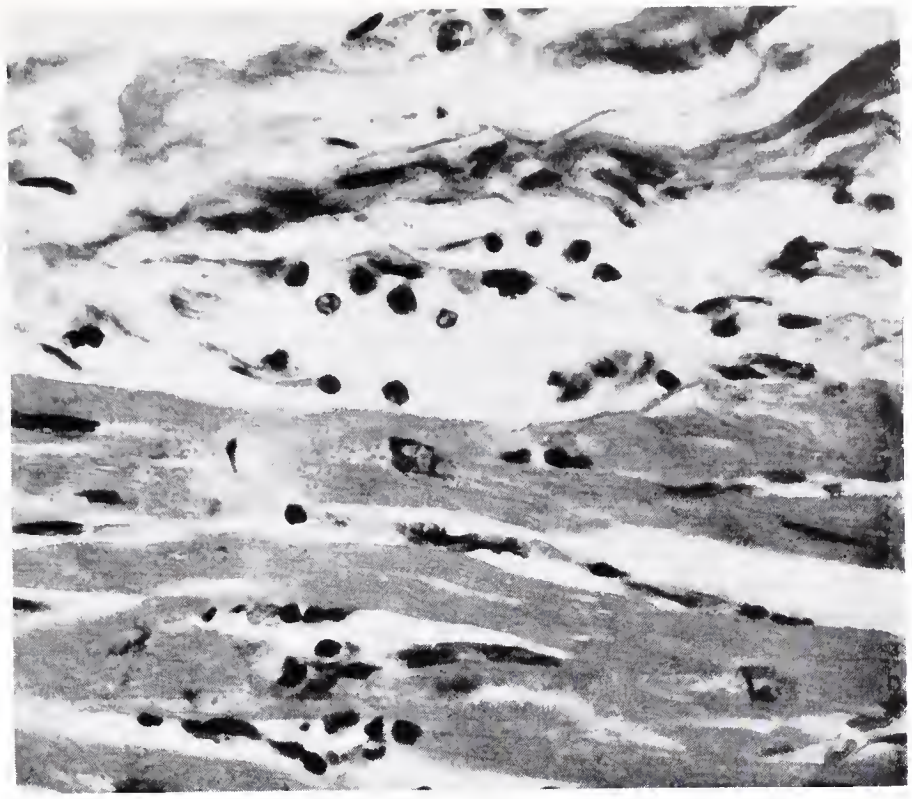


FIG. 2.—*Section of subepicardial myocardium demonstrating degeneration of myocardial fibers and round cell infiltration.*

assumed to have heart failure due to rapid atrial fibrillation of undetermined cause. He was treated with digoxin and diuretics and lost sixteen pounds after one week of hospitalization. On the day after admission he developed nausea and vomiting, and although he had received only 2.75 mg of digoxin in 48 hours, these symptoms and the bigeminal rhythm were interpreted as evidence of digitalis toxicity and digoxin was discontinued. Quinidine in doses of 400 mg q.i.d. was started and bigeminy ceased. Despite clinical improvement and diminution of edema, the pleural effusion persisted. A thoracentesis was performed on the sixth hospital day; at this time the patient became icteric and febrile to 101° F. Thereafter, confusion, disorientation, vomiting, and diarrhea appeared. Digoxin was reinstituted in doses of .25 mg daily from the fifth through the seventh days but was again discontinued when bigeminal rhythm reappeared.

On the thirteenth day of hospitalization, he began to improve, with clearing of the icterus, lysis of the fever, and disappearance of gastrointestinal symptoms. His blood pressure, however, fell to the level of 110/50 at this time, and remained there until his sudden, unexpected demise on the seventeenth day.

Autopsy findings: The right pleural space contained 1,000 cc of clear serous fluid, while the left pleural cavity was obliterated by dense fibrous adhesions. The pericardial sac contained approximately 30 cc of clear serous fluid. The heart weighed 380 grams, and the left and right ventricular walls were 1.2 and 0.3 cm thick, respectively. Serial sections of the coronary arteries revealed diffuse arteriosclerosis without gross occlusion. The myocardium was soft and flabby. The aortic valve was thickened with partial fusion of the valve leaflets. The lungs were soft and congested and sectioning revealed edema. The tracheobronchial tree contained thick mucoid secretions. The liver was pale tan, smooth, and showed mottled yellow-green areas. The kidneys showed a granular congested cortex.

Microscopic description: Widely separated aggregates of lymphocytes, plasma cells, and eosinophiles were scattered over the pericardium. Similar infiltrates were found between the myocardial fibers. There was hypertrophy of myocardial fibers and minimal congestion of intramyocardial vessels (Fig. 2). The lungs showed patchy areas of acute inflammatory cells, and the pulmonary vasculature was markedly congested. The spleen and liver also showed congestion. Inflammatory infiltrates of lymphocytes and plasma cells, with a few scattered neutrophiles, were present in the portal triads and extended into the hepatic parenchyma. The renal tubular epithelium showed scattered cellular fragmentation with nuclear pyknosis. The glomeruli were uninvolved. The meninges showed scattered inflammatory infiltrates.

Blood obtained at postmortem examination was inoculated into guinea pigs with resultant growth of leptospirae in the animals. These were serologically typed as L. pomona by the agglutination-lysis technique. Efforts to demonstrate the organism in the patient's tissues were unsuccessful.

Death was attributed to leptospirosis due to L. pomona, with myocarditis, pericarditis, pulmonary

congestion, hepatitis, renal tubular degeneration, and meningitis.

DISCUSSION

Leptospira pomona was isolated by Clayton *et al*[6] in Pomona, Australia, and given its name by Derrick[7] in 1942. The reservoirs and hosts are the opossum, swine, cattle, and dog.[8] Gsell[9] showed the organism to be responsible for swineherd's disease, an influenza-like illness with signs and symptoms of aseptic meningitis. This is confirmed by Schaeffer's series[10] of patients who demonstrated fever, chills, headache, and back pain. "Several" of these developed aseptic meningitis. None showed hepatic or renal involvement. Woodward[11] stated that the clinical manifestations resemble the mild form of Weil's disease, with a low incidence of icterus and death. McCrumb[8] believed that L. pomona has a particular predilection for the nervous system.

Edwards and Domm[12] stated that although cardiac manifestations are not uncommon in the leptospiroses, they are seldom of clinical importance. However, in Sodeman and Killough's series[13] of 80 patients with Weil's disease, eight had definite evidence of myocardial involvement, including two cases with congestive heart failure. All eight had electrocardiographic abnormalities. Bertucci,[14] in his review of Weil's disease, mentioned a cardiac type simulating congestive heart failure.

Cardiovascular signs reported in leptospirosis include gallop rhythm, pericardial friction rub, cardiac enlargement, tachycardia, premature beats, and atrial fibrillation.[15,16,17] Electrocardiographic changes include prolongation of the QT and PR intervals, defective atrioventricular conduction, T wave changes, and low voltage with slurring and widening of the QRS.[16,17] Gsell[4] and others[10,11] concluded that the changes in the heart were reversible.

The inference that leptospiral myocarditis is more common clinically than is recognized is suggested by the report of Koppisch and Bond[2] who found myocarditis in eight of 13 fatal cases of leptospirosis. Gore and Saphir[1] found myocarditis in seven of eight fatal cases of Weil's disease. The presence of myocarditis was not generally suspected antemortem, despite such suggestive findings in many of the cases as cyanosis, dyspnea and orthopnea, significant hypotension with a feeble pulse, chest pain, electrocardiographic abnormalities, and features of congestive heart failure—including distended neck veins, serous effusions, swollen, tender liver, and dependent edema. To these I would add the important finding of extreme sensitivity to digitalis, as exhibited in this case.

Arean[3] described the pathological findings in 16 cases of myocarditis due to Weil's disease. The findings were nonspecific; and no leptospirae were identified in the cardiac tissues of any of his cases.

Sutliff *et al*[5] stated that the recognition of leptospirosis in the United States may be lagging behind the actual occurrence of the disease because of a limited conception of the clinical manifestations. Indeed, the diagnosis was not entertained in this case until after the patient became jaundiced, a sign which may be absent in many cases.[18]

SUMMARY

An account is given of a patient manifesting congestive heart failure, which proved to be due to Leptospira pomona myocarditis. A resume of postmortem findings is included. The clinical and electrocardiographic findings of leptospiral myocarditis are briefly reviewed.

Myocarditis is more common in leptospirosis than is generally recognized. A wider knowledge of the clinical manifestations of this disease would probably lead to its more frequent diagnosis.

ACKNOWLEDGMENTS

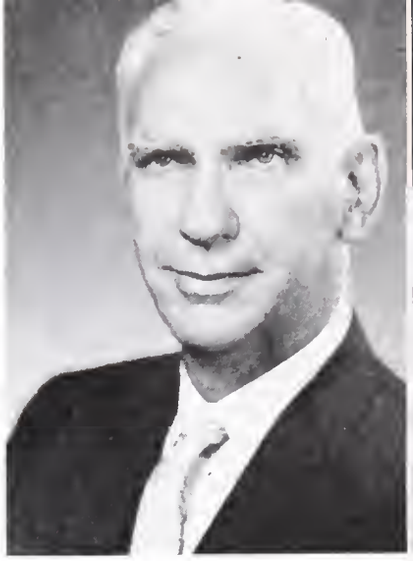
I wish to thank Lt Colonel James MacNamee, VC, USA, for performing the bacteriologic and serologic studies and Captain George J. Vennes, MC, USA, for the postmortem examination. Appreciation is also expressed to Colonel Robert J. Hoagland, MC, Lt Colonel Robert H. Moser, MC, and Lt Colonel Frank L. Miller, MC, USA, for their advice and criticism in the preparation of this paper. ■

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The President's Page



In May, I took part in the Western Forum on Medical Education in San Francisco, sponsored by the Western Interstate Commission for Higher Education (WICHE). The purpose of this forum was to try to answer the question—How can the West meet its medical manpower needs?

Those in attendance were from various walks of life—practicing physicians, medical school faculty, deans of universities, lawyers, architects, legislators, and executive personnel. Except for the fact that the population gain in the West was 18.5 per cent as compared with 7 per cent for the rest of the nation, it seemed to me that the medical manpower needs of the West were also the manpower needs of the whole U.S.A.

In the United States we are beginning to lose ground as far as the ratio of physicians to population is concerned* This is due to the rapid population boom, and is aggravated by the fact that more and more people have more and more dollars to spend on medical care. Conservative estimates are that by 1972 we will need at least 11,000 medical graduates a year (7,324 graduated in 1963) in order to keep up with population growth, not to say anything about increased patient demands. These statistics, coupled with the fact that medical education is the most expensive field of education in both space required and personnel needed (an outlay of $1,000,000 is needed for every five students) place us right up against a dilemma which is not being solved, nor is it going to be solved very easily.

It has been suggested that the shortage might be partly or temporarily overcome by licensing more foreign graduates, by increasing the efficiency of doctors, by having more people trained as medical aides to help the doctor with routine work, by making better use of our training facilities, and by encouraging more students to go into medicine.

First: in the U.S.A., medicine is the only professional field in which we must depend on foreign-trained personnel in order to keep abreast of our present needs. Every year, in this country, 20 per cent of the new M.D. licenses are foreign graduates! In fact, at the present time 10 per cent of all of the physicians in the U.S.A. are foreign graduates. But even with the help of the medical teaching facilities of other countries (countries which, with the exception of Israel, are also short of medical personnel) we are losing ground. Even though it would be better if we did not have to depend on foreign graduates, one wonders how long this influx will continue. Past experience shows that it will continue as long as the economic position of the American doctor is better than that of doctors in other countries. Socialization of medicine in the U.S.A., with the inevitable lowering of economic standards and free-enterprise opportunities of the practice of medicine, would bring this influx of foreigners practically to a standstill. Note the fact that in England at the present time, one-third of the medical graduates leave the country for more fertile fields—areas which are better economically or where there is more freedom to grow and to achieve.

Second: how does one go about increasing the efficiency of doctors? Should we work in groups? Should the practice of medicine be centered in a hospital? How much more of a patient's care can a doctor delegate to an aide? What would happen if all doctors went on a 40-hour or even a 48-hour week, with the resultant decrease of doctor availability by 20 to 33 per cent? These are questions which remain unanswered, but which will no doubt have to be answered in the near future. For example, under socialized medicine in England almost 75 per cent of deliveries are done by nurse midwives, in Sweden it is 90 per cent, and in Denmark it is almost 100 per cent. Can you imagine the hue and cry that would be raised right now if the obstetricians in the U.S.A. turned over 50 per cent of their deliveries to nurse midwives? The fact is that the lawsuit-minded American public is forcing practicing physicians to allow their aides to do less and less. But as the population-

* Since the recent articles published by both the AMA and the Public Health Service, physician-population ratio has become a controversial matter.

versus-physician ratio rises, and unless we are able to increase the number of medical graduates to 11,000 a year, the American public will have to become satisfied with less and less personal attention from their doctor. The American College of Obstetricians and Gynecologists is now trying to anticipate, by setting up training areas for nurse midwives, the day when there will not be enough family physicians or obstetricians available to deliver all the babies which are being conceived. Can we continue to afford the luxury of highly trained doctors to do *everything?* Or will we have to regress to a situation like that in Russia, where less well-trained "doctors" (mostly women) take care of the routine minor illnesses—such as is done by hospital corpsmen in the navy and by the "medics" in the army?

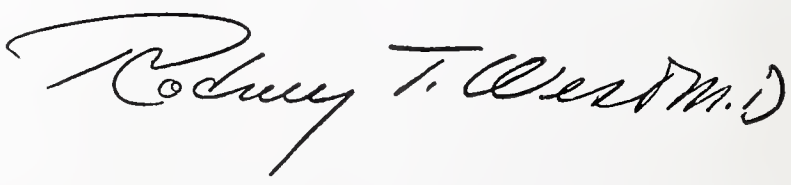
Third: the attrition rate of medical students at present amounts to 12 to 13 per cent; that is, only 87 out of every 100 freshmen in medical school ever receive an M.D. degree. This wasteful attrition rate could possibly be reduced by encouraging more of the better grade of student to enter medical schools. Following sputnik, medicine lost much of its drawing power for the scientific-minded to the more glamorous areas of nuclear physics, space engineering, electronics, and so forth. Last year, however, for the first time in recent years there was a definite increase in the number of medical school applicants. Many good students are still being deterred by the increasingly long period of training required and the high cost of this training. They also seem to feel that the financial compensation of the practice of medicine is not worth the long hours of work when it is coupled with the constant threat of nuisance lawsuits and the socialization of medicine with its federally centered dictatorial powers. To counteract the above, however, most state and county medical societies have medical career committees which are actively trying to interest high school and undergraduate students in careers of medicine or other paramedical fields—and, of course, you all know of our constant efforts to counteract socialism and protect the freedom of the U.S. doctor.

Once a student makes his decision to enter the field of medicine, he finds he is immediately faced with the dollar sign. Medical education is not only costly for the state and endowed institutions but also for the student himself when all factors are taken into account—such as loss of earning power because of prolonged training. It is estimated that it costs an unmarried student $10,000 a year to go to medical school. If he is married (three out of five are) this goes up to $12,000—and if there are children (one-half of the married students are parents) this increases to $16,000 a year. It is fortunate that 45 per cent of medical students still come from families earning over $10,000 a year, because 69 per cent of the cost of their education is being furnished by their parents; 23 per cent from part-time work, and 8 per cent from loans. In the case of married students, the spouse is able to earn or account for 24 per cent of the expense.

The above figures are being twisted and used by the Federal Government to prove that only those from well-to-do families can afford to go into the medical field and that there is a big financial need not only for medical school construction but also for helping needy students to go to medical school. I feel, however, that medical students do not need to be subsidized and if they need financing, the AMA already has a student loan program which had $18,164,260 in bank credit available for loans to medical students as of June 30, 1963. Once a doctor is out of training he should be able to pay back any justly incurred debts and not be beholden to the Federal government.

Now that we have interested the good student in becoming a doctor and have helped sufficiently with his financial needs—he will soon be faced with another dilemma. Where can he get into a medical school? Will we have the facilities to graduate 11,000 medical students by 1972? Where will we get the financing for the facilities and the faculties? The construction cost alone for a medical school with an entering class of 96 is over $25,000,000 and requires an annual operating budget of $5,000,000 and a faculty of 150. What are the answers, and who has them?

I will leave you with these thoughts. In the next issue of the JOURNAL, I will tell about the WICHE program and how it affects Hawaii, and what the Western states are actually doing in attempting to solve their medical manpower needs.



HAWAII MEDICAL JOURNAL

Editorials

Professional Health Planning

The Health Facilities Planning Council of Hawaii, an offspring of the Hospital Association of Hawaii during Dr. P. Howard Liljestrand's presidency of that organization, in 1961, was approved by the Hawaii Medical Association's House of Delegates in 1962 and 1963, and is now in business. Its headquarters is in Suite 820 of the Ala Moana Building. Its President is Richard K. C. Lee, M.D. Its full-time Executive Director is Edward W. Colby, M.D. (Albany), M.P.H. (Harvard). It is financed by a Federal grant of $219,000 to cover its first three years of operation.

Hospital planning is the Council's primary business. Their introductory publications have been kind enough not to describe the earnest but fumbling and ineffectual efforts that have been made in this direction in Hawaii during the past twenty years. Nor will we detail them here. It is enough to say that they have been made, under the auspices of such existing agencies as the Honolulu Chamber of Commerce and the Oahu Health Council, and that they have accomplished virtually nothing.

But hospitalization is one of our most costly health services. Not only is it costly to the occupant of a hospital bed; it is costly to every taxpayer, for hospitals are extremely expensive to build and to operate. And free competition, so effective a weapon against high prices in the grocery or automobile business, is not much help in the hospital business, for hospitals don't go broke and go out of business—they raise their rates, or are subsidized. Or both!

So planning for the expansion of hospital services, in such a way that hospitals will themselves be able to go along with the plans, can be financially advantageous to everyone concerned, and that means everyone. But it can't be accomplished by amateurs with good intentions. It has to be done by professionals with know-how, and with some influence over the disposition of the government funds, without which only limited expansion of hospital facilities is possible.

The fact that this is being done now, by citizens of our own community, on a local level, is heartening. The caliber of the executive officer in charge, Dr. Colby, is as large as one could wish. The Board of Trustees is broadly representative of business, banking, labor, education, hospitals, legislators, and the medical profession (Drs. Mills and Nishigaya). County committees represent each island.

The Council has entered as of July 1 last upon the first phase of its operation: collection of information. They invite contributions of opinions and facts from all interested persons. They are entitled to expect our full support and cooperation, not only in this relatively painless phase, but also in the period when they will be advising us what we should do. If you think you might feel critical of their eventual recommendations, the time to offer them the special knowledge on which you might base such criticism is now! ■

In Memoriam – Doctors of Hawaii

This is the forty-fifth installment of In Memoriam—Doctors of Hawaii.

Frederick Eugene Trotter

Frederick Eugene Trotter was born May 7, 1873, at Fort Fetterman, Wyoming, the son of Lt. Col. Frederick Eugene Trotter, USA, and Dutilly Frances (Sickles) Trotter. He was the grandson of Jonathan Trotter, the first mayor of Brooklyn, New York.



DR. TROTTER

He was educated in the public schools of Vancouver, Washington, and at Bishop Scott's Academy, Portland, Oregon. He spent one year at Stanford University, one year at the University of Oregon, and two years at the University of Virginia, graduating with a medical degree in 1895. Dr. Trotter interned in hospitals in New York until the beginning of the Spanish-American War.

Dr. Trotter began his professional career as an Acting Surgeon in the United States Army, August 19, 1898. He served until July 18, 1899, when he was transferred to the U.S. Marine Hospital Service as an Acting Assistant Surgeon. On July 27, 1899, he was advanced to Assistant Surgeon and was later commissioned as a Past Assistant Surgeon and Surgeon.

Dr. Trotter held a number of important federal posts prior to coming to Hawaii. These included immigration duty at Ellis Island, New York; management of U.S. Quarantine Station, Mullet Key, Tampa Bay, Florida; direction at Tampa during the yellow fever epidemic; yellow fever duty at Dry Tortugas, Florida; quarantine service at Havana, Cuba; Quarantine Officer at Cienfuegos, Cuba; Executive Officer to the Chief Quarantine Officer at Havana; Chief Quarantine Officer in Cuba under the late General Leonard Wood; outgoing Quarantine Officer at Havana in the office of the U.S. Consul-general; U.S. Marine Hospital, San Francisco, and assignment to plague duty in that city.

On April 9, 1900, Dr. Trotter married Harriet Everett Barling in Cienfuegos, Cuba. The couple had two sons and four daughters: Harriett, Frederick Eugene III, Marian, John, Nancy and Frances.

Dr. Trotter arrived in Hawaii on March 12, 1912, to become Chief Quarantine Officer for the Territory, after having been Medical Inspector of Immigrants at San Francisco and Quarantine Officer at that port.

In September, 1919, he was named President and Executive Officer of the Territorial Board of Health. On May 26, 1937, under provisions of an act passed by the legislature creating the position, he was named Territorial Commissioner of Public Health.

Dr. Trotter died on August 7, 1939, at the age of 66.

Among the organizations to which he belonged were: State and Provincial Health Authorities of North America, of which he was president in 1929; American Medical Association; charter member of the American Society of Tropical Medicine; American Editors and Authors Association; American Public Health Association; American Association of School Physicians; American Eugenics Society; National Tuberculosis Association; Hawaii Medical Association; Loyal Legion Military Surgeons; and the Honolulu Chamber of Commerce.

Sosuke Ochiai

Sosuke Ochiai was born on April 24, 1882, in Omura, Oaza Suishin-mura, Saitama gun, Saitama Prefecture, Japan. He was the son of Kumakichi and Nami Ochiai. His father was a well-to-do farmer and Sosuke attended a nearby primary school and helped his father. When the farm work proved too hard for a 13-year-old boy, he begged to be sent to Tokyo to learn a trade. However, when he was apprenticed to a tradesman in Tokyo, he was found too delicate and was discharged with the remark, "You can do nothing except wash rice and sweep the floor thirteen times daily." Many years later the doctor still remembered this cruel remark.

In 1899, he came to Hawaii with an uncle. After he had gained a knowledge of English, he decided to go to the mainland to study medicine. The fall of 1907 found Sosuke at the University of Colo-

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HAWAII MEDICAL JOURNAL

This Is What's New!

• The **transplantation of bone marrow** from one individual to another may result in a series of pathological events often resulting in death of the host. One of the French leaders in this field has recently found that preservation of the bone marrow cells in **Tyrode's solution** for two hours reduces the frequency of acute and chronic syndromes following marrow infusion and irradiation. (*Blood* [July] 1963.)

• **Smoking** causes an **increase in free fatty acids.** This is bad enough if a person is concerned about coronary heart disease. Even worse is a complete lack of rise of free fatty acids after smoking. This means the patient either has absent or **nonfunctioning adrenal glands and sympathetic nervous system.** An intact sympathetic nervous system and functioning adrenal glands are necessary to produce the rise in free fatty acids on smoking. (*Circulation* [July] 1963.)

• It may be advisable to look beyond the nose in patients with nasal polyps. The discovery that approximately one-third of patients with cystic fibrosis had nasal polyps has led to the advice that all children and adolescents with **nasal polyps** or **sinusitis** be examined for **cystic fibrosis.** (*Arch. Otolaryngol.* [Aug.] 1963.)

• The University of California has been treating **hyperthyroidism** with I^{131} for over 16 years. Of 650 patients with hyperthyroidism so treated, two have developed **leukemia:** one three years and the other 14 years after treatment. Whether or not a causal relationship between I^{131} therapy and leukemia exists, the numbers of patients developing leukemia after I^{131} will increase with the square of time since the introduction of I^{131} therapy. (*California Med.* [Apr.] 1963.)

• The battle as to whether polyarthritis with psoriasis is a variant of rheumatoid arthritis or a distinct syndrome, psoriatic arthritis, continues to go on, but with more and more experts in the psoriatic arthritis camp. After a hard look at the whole problem a physician from Newcastle upon Tyne decides, "It is concluded that the diagnosis of **psoriatic arthritis** should be made when psoriasis and polyarthritis occur together in the **absence of subcutaneous nodules and a serum rheumatoid factor.** Distinctive clinical and radiological features are found only in a minority of cases." (*Ann. Int. Med.* [June] 1963.)

• The subcutaneously implanted **electronic pacemaker** for complete **heart block** is being used with increasing frequency as technical improvements on the gadget are made. The new improvements consist of reduction in size and the addition of rate and amplitude controls. A recent series reports 42 patients with complete heart block in which the pacemaker was implanted. Thirty-four patients survived, with an average followup of approximately one year. (*Dis. of Chest* [Mar.] 1963.)

• A group in Cleveland analyzes its results in **treating high blood pressure** by **surgical relief of occlusive renal artery disease.** Their results: Diastolic pressure decreased to normal levels in 62 per cent. The pressure decreased (but not to normal levels) in 12 per cent more, and in 22 per cent it was unchanged. They found no way of predicting which patient with occlusive renal artery disease was going to respond well to surgery. As a general rule the younger patients did not do as well as the older patients and those with long-standing hypertension did less well than patients with hypertension of less than one year's duration. Renal function tests were not helpful in predicting the response to therapy. (*Circulation* [June] 1963.)

• A New Yorker makes a plea for more emphasis on **theoretical medicine,** especially in medical teaching. He suggests that leadership in medicine may be more dependent on work carried out in a bare room with blackboard and chalk than in a room packed with computers, electron microscopes, amino acid analyzers, and so forth. He fears that the increasing channeling of young physicians' talents into **mechanical activities** tends to stifle the budding physician's **creativity.** (*JAMA* [June 29] 1963.)

• A **40-year gestation** finally terminated in delivery. A 78-year-old South American woman who had severe abdominal pain for 40 years passed fetal bones after an enema. She refused surgery and continued to pass fetal bones over a five months' period. After all the bones had passed, the abdominal symptoms subsided. In reviewing the history, the onset of the pregnancy was dated to some 40 years previously. It was felt to be an intra-abdominal pregnancy with fetal death at about three months. (*Semana Medica* [Dec. 3] 1962.)

FRED I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

Book Reviews

★Transurethral Prostatic Surgery

By Kyril B. Conger, M.D., F.A.C.S., 140 pp., $9.00, Williams & Wilkins Co., 1963.

THIS SHORT BOOK is a real gem; a succinct, clear, and very practical treatise on transurethral prostatectomy. It is only for the urologist, and primarily for the urological resident. Although it duplicates in a sense the original works of Nesbit and Barnes in this highly specialized field, it brings right up to date all useful knowledge these men can possibly need in learning the difficult technic and important pre- and postoperative care. In addition many little but vital tricks in the use and care of the resectoscope are included. The book is highly recommended for the genito-urinary surgeon.

WALTER S. STRODE, M.D.

Fundamentals of Nerve Blocking

By Vincent J. Collins, M.S., M.D., with the assistance of Emery Andrew Rovenstine, M.D., 354 pp., $9.50, Lea & Febiger, 1960.

IN PART, this relatively small volume represents the clinical approach to the treatment of pain by nerve block techniques as practiced at Bellevue Hospital. Therefore, the author has attempted a concise discussion of a multitude of diverse conditions. Of necessity, many of the important details of complex phenomena related to pain have been either neglected completely or only superficially touched upon. Although it is commendably put together, including chapters on the pharmacology of local anesthetics, toxicology, physiologic mechanisms of pain, etc., one cannot help but regard this work as a sort of compendium of material already in print.

The application of chemical nerve blocking for pain syndromes and diagnosis is not new. Certainly the techniques have been worked out long ago as evidenced by the author's inclusion of many illustrations from other standard references on the subject. He does, however, present a few refreshingly new diagrams with adequate explanations in the text.

This is a very readable book with a well conceived plan of organization. A few typographical errors occur, such as "familiar" and "hyperhidroses" (p. 197) rather than "familial" and "hyperhidrosis" respectively. The inclusion of a Code of Classification of Therapeutic and Diagnostic Nerve Blocks is unique and should be of value in statistical management of therapeutic results.

In summary, this volume is recommended reading for any physician interested in a rapid survey of nerve blocking as an adjunct to the treatment and diagnosis of pain problems.

GEORGE F. PARKER, M.D.

★Gastroenterology, Vol. 1, 2nd Ed.

By Henry L. Bockus, M.D., 958 pp., $25.00, W. B. Saunders Company, 1963.

THIS MONOGRAPH is another excellent work, topping the first edition in quality. It is well organized in sections for quick reference, with a good bibliography appended, should one want further details. Many excellent illustrations help explain the material presented. The x-rays presented are in the same black and white as a negative, giving realistic pictures. Each chapter is preceded by a detailed outline of its contents. One third of this volume is devoted to peptic ulcer and its many ramifications. This work will continue to be the leader in its field, being organized so it can quickly help the busy man doing a volume practice as well as the man who wishes to evaluate a problem in depth.

RAYMOND M. DEHAY, M.D.

★ means highly recommended.

Know Your School Psychologist

By Wilma E. Hirst, Ed.D., 240 pp., $6.75, Grune & Stratton, 1963.

WRITTEN BY AN EDUCATOR, this book belongs more on an educator's shelf than in a doctor's office. Nonetheless, for those interested in the varying aspects of pediatric mental health, it will be a helpful adjunct and reference.

The first 130 pages deal with the varying emotional problems encountered by individual students, their parents and their teachers; these are exemplified by interesting case histories.

The last half of the book explains the servicing functions of the school psychologist to the school as a whole and to the community.

ROBERT G. DIMLER, M.D.

★The Kidney: Medical and Surgical Diseases, 2nd Ed.

By Arthur C. Allen, M.D., 770 pp., $26.50, Grune & Stratton, 1962.

THIS SECOND EDITION, extensively revised, includes advances in the knowledge of renal disease which have occurred during the past eleven years.

The format is about the same, with chapters on embryology, anatomy, normal and abnormal physiology, uremia, malformations, diseases of the glomeruli, the nephrotic syndrome, diseases of the tubules, interstitial nephritis, specific infections, pyelonephritis, calculi, diseases of the vessels and neoplasms. The type is legible and easy to read, and the paper is of good quality. The illustrations are truly excellent, and are arranged in 380 plates made up of 1,115 separate illustrations, including a number of electron micrographs taken at a magnification of 4,000 or greater.

The bibliography is extensive and is arranged alphabetically at the end of each chapter in sections according to content. For example, the chapter on diseases of the glomeruli contains 203 references, arranged alphabetically in five sections.

The author is a pathologist, and the book is oriented toward etiology, pathogenesis, and gross and microscopic pathology; there is relatively little on the clinical picture, and nothing on therapy. The book will therefore be utilized chiefly by pathologists and pathology residents, and to a lesser extent by internists and surgeons who want to become familiar with the pathologic aspects of renal disease. For this purpose it is admirably suited because of the abundance of magnificent illustrations depicting the gross and microscopic pathology of medical and surgical diseases of the kidney.

I. L. TILDEN, M.D.

★Clinical Disorders of the Heart Beat, 2d Ed.

By Samuel Bellet, M.D., 1105 pp., $28.00, Lea & Febiger, 1963.

THIS IS A REVISED and expanded second edition of an earlier comprehensive text on cardiac arrhythmias. The many new discoveries in this field since the first edition in 1953 have been included, and among these are the physiological studies, hypothermia, artificial pacemakers, defibrillators, and other electronic devices. Each subject is treated in full detail with generous sections on physiology, animal experimentation, and theoretical considerations, as well as complete therapeutic sections on diagnosis, drug dosage and administration, and prognosis. Each chapter has an extensive list of references and in outline form, the essential items of each section are sum-

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Hawaii Academy of General Practice

COMPARTMENTALIZED THINKING

They say that Socialized Medicine in its advent will be as inevitable as death and taxes. They mean that it already has its foot in the door, and is getting in now.

Perhaps so! Some of us, however, are not so pessimistic about its inevitability, just so long as we have gifted spokesmen like Dr. Annis, and means and media with which to get his message broadcast.

King-Anderson was squelched last year. Opinion polls indicate a decline in support of "Fedicare" for the elderly. What then, is this "foot-in-the-door" that is always mentioned by the scaremongers?

COMPARTMENT A

Very few physicians are proponents of Fedicare. Many are too busy, personally, to think about the consequences of a nationalized health plan such as they have in England. Of those that do any cogitating, many go no further. It must be a very few who get into any doing-something-about-it. The rest of us sit-backs might at least encourage the few Georges amongst us by giving them financial, verbal, or moral support and encouragement (Join the AAPS!).

But at least we list ourselves as against Socialized Medicine, whatever broad concepts that term includes. Do we really know what we are against?

We might agree that we are united in being—

- *against* a Federal health insurance plan in which the governmental bureau will manage and control our practice of medicine.
- *against* a system in which control is so far away towards the hub that personal problems will become impersonal.
- *against* an implacable system of set fees that will forbid any other fees even if justified by the exigencies of the procedure or the circumstances of the patient.
- *against* a system in which doctors will have very little, if any, say about its administration.
- *against* a system that is primarily a contract between the government and the people in which these two bargain for the services of unrepresented physicians.

COMPARTMENT B

Nearly all of us are members and supporters of HMSA. Mostly with a minimum of protest, we allow our practice of medicine to be managed, and managed, and managed—a central office that is relatively far away and impersonal about problems—a system of set fees—a body that does *not* have doctor control—in which our services and efforts are bargained over without a by-your-leave.

This was the foot in the door!

When we doctors allow *any third party* to formulate and manage a system of medical care, whether that party be a community group or the Federal government, we step in the direction of accepting socialization of medical care, which is essentially the regimentation of the practice of medicine.

Here again we find ourselves guilty of compartmentalized thinking. Perhaps what we need to do is to search for the Consistent Physician, and if we find him to be completely consistent, let's gather around and organize a new society. A member would have to take an oath to be against "Socialized Medicine." He would then have to withdraw his membership in HMSA's regular and Medicare plans and become nonparticipating.

He could participate in the Honolulu Foundation for Medical Care—because it is truly a doctor's plan, doctor-managed and controlled.

If we all saw it this way and participated *only* in the Foundation Plan, then we could push Fedicare's foot out of the door and keep it there.

J. I. FEDERICK REPPUN, M.D.
Secretary-Treasurer

Help yourself to a good feeling and reflect credit on Hawaii at the same time.

Send a check to your school via AMA-ERF.
They get the full amount in your name—nothing is deducted.

New Members



Perry E. Rowe, M.D.

Pahala, Hawaii
General Practice
University of Oregon Medical School, 1941
Internship—Swedish Hospital, Seattle, Wash.



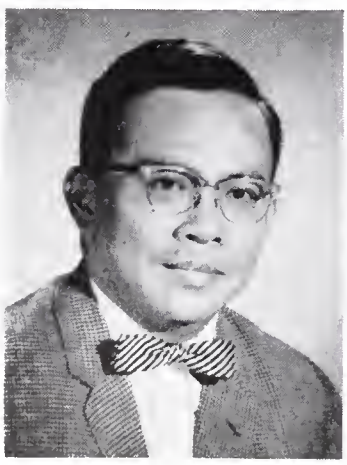
Robert Eugene Boyd, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
Urology
Ohio State University, 1952
Internship—St. Rita's Hospital, Lima, Ohio
Residency—Wayne County General Hospital, Eloise, Mich.



Hugh Lloyd Davis, Jr., M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
Internal Medicine
University of Chicago, 1954
Internship—University of California, San Francisco, Calif.
Residency—University of California Hospital, San Francisco, Calif.
San Francisco General Hospital, San Francisco, Calif.



Walter F. Char, M.D.

1441 Kapiolani Blvd.
Honolulu, Hawaii 96814
Psychiatry
Temple University School of Medicine, 1945
Internship—Temple University Hospital, Philadelphia, Pa.
Residency—University of Pittsburgh, Pittsburgh, Pa.
Temple University Hospital, Philadelphia, Pa.



Daniel Dooley Palmer, M.D.

1481 South King Street
Honolulu, Hawaii 96814
Dermatology
University of Michigan, 1956
Internship—Hurley Hospital, Flint, Mich.
Residency—Mayo Clinic, Rochester, Minn.



Clarence Melville Baugh, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
General Surgery
University of Chicago, 1954
Internship—University of Chicago, Chicago, Ill.
Residency—University of Chicago, Chicago, Ill.
University of Tennessee, Memphis

County Society News

Hawaii Medical Association

Hawaii

Guest speaker Dr. James Cooney was presented with a key to the city by Supervisor Elroy Osorio at the May 10 meeting. Volunteers to serve on HMA committees were called for but there being none, appointments were made from last year's list. A study will be made to see if expenses of representatives can be covered. The offer of Dr. Joseph Stokes, III, to send postgraduate lectures on tape to Hawaii was discussed. Dr. M. L. Chang offered to copy the tape recordings so they could be circulated to the rural areas.

Dr. Miyamoto reported on the HMA Annual Meeting. A unanimous vote granted an interest-free loan to a Tulane student who is working for his Master's Degree. The subject of Dr. Cooney's talk was "Viruses in Cancer."

* * *

A second May meeting was held on the 31st to hear Dr. William Beierwaltes talk on the Management of Renal Disease, Hypertension, and Heart Disease. Dr. Perry E. Rowe was unanimously accepted as a new member. Approval was given the Hawaii Heart Association's rheumatic fever prophylaxis program. A request to appoint Dr. Toru Nishigaya Assistant Medical Director of HMSA was approved unanimously.

The Society went on record as favoring the election of a neighbor island doctor to the HMA presidency every fourth year. It was voted to sponsor a third Operation Swallow for the 3-month to 30-year age group.

* * *

The June 20 meeting was opened with a movie called "Life in Your Hands." This was followed by another short movie on ano-rectal surgery presented by Dr. Verne Waite. The Society was advised that the Department of Health will not assist or endorse Swallow III. In view of this the Society rescinded its action of May 31.

Dr. Francis Wong brought up the matter of placing a cardio-monitor in each operating room at Hilo Hospital. The question of supplying similar equipment to rural hospitals was raised. Action was deferred pending receipt of information on the cost.

* * *

The July 26 meeting was opened with a discussion on the delinquency status of members who have not paid their legislative assessment. Literature on the Message of the Month PR project was distributed. Members were asked to hold laboratory work to a minimum between August and December since there will only be one technician working at the Department of Health during that time. The guest speaker, Dr. M. Eugene Lahey, spoke on The Management of Iron Deficiency Anemia.

Honolulu

Approximately 180 doctors were present at the June 4 meeting when new members Ann B. Catts, Herbert M. Nakata, Emiko Sakurai, Adela G. Sanidad, Edna Watt Schrick, Sorrell H. Waxman, Robert Weiner, and Clarence B. N. Chun-Ming were welcomed into the Society. The President announced that Mr. H. Tom Thorson of Okanogan County (Washington) would assume his duties as Executive Secretary on June 15. Dr. Ivy briefed the membership on the new PR program of the HMA, especially as it relates to Operation Hometown. Dr. William Moore explained how the Medical Message of the Month project will work and asked for the members'

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MINUTES OF THE COUNCIL MEETING

July 24, 1963—6:00 p.m.
Oahu Country Club, Honolulu

PRESENT

Dr. Rodney T. West, presiding: Drs. Allison, Andrews, Chinn, Fong, Giles, Lum, Miyamoto, Nishijima, and Wade, plus Mr. H. Tom Thorson.

MINUTES

The minutes of the February 13, 1963, meeting were approved as published.

ANNOUNCEMENTS

Dr. West announced that the AMA Institute would be held in Chicago, August 22-23 and asked if anybody would be there. It was noted that Mr. Lytle will attend this meeting in conjunction with the Public Relations Conference.

COMMUNICATIONS NOT REQUIRING ACTION

A letter of acknowledgment and thanks from Dr. Ichitaro Katsuki was read.

REQUESTS FOR CONTRIBUTIONS

Letters from Saint Louis High School and the John Howard Association soliciting contributions from the Association were reviewed.

ACTION:

It was voted to reiterate the policy that contributions should be made on an individual-member basis.

FRANCIS I. DU PONT & CO. PROPOSAL

An offer to set up a program under HR 10 was reviewed, as was the action by the AMA House of Delegates relative to offering a national plan.

ACTION:

It was voted not to pursue individual plans and to await the AMA Plan.

SECRETARY'S REPORT

The circulated report was reviewed.

ACTION:

It was voted to accept the additions, deletions, changes in classification, and dues waiver as recommended in the report.

It was voted to ask Maui County whether J. M. B. Sowers' tour of duty is still on a temporary basis.

It was voted to drop the following members who have not been recertified for dues waiver: James Luee, Ransom J. Arthur, and Walter Watt.

It was voted to try to work out the status of Donald Brown with his county secretary.

It was voted to defer action on the six members whose dues waiver status is in question be-

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CLARENCE W. TREXLER, M.D.
1897-1963

The State of Hawaii has lost one of its pioneer and leading eye, ear, nose, and throat specialists. Dr. Clarence William Trexler died on June 7, 1963, in Honolulu at the age of 66 of acute hipatitis.

He was born in Winston-Salem, North Carolina, and did his undergraduate work at Roanoke College. He graduated from the Medical School of the University of Virginia in 1926. He received his postgraduate training at the University of Vienna and Lesarka University in Bratislava, Czechoslovakia, in 1930-31.

He was a member and leader of many civic and medical organizations. These included the Commercial Club, the Oahu Country Club, the Mercury Club, and the Lions Club. He served as President of the latter two organizations. He was an active member and held many offices, including the presidency in the Pacific Coast Oto-Ophthalmologic Society. He was also a member of the Pan-American Association of Ophthalmology and the American Academy of Ophthalmology and Otolaryngology, and an associate fellow of the Aero-Medical Association. He served as President of the Honolulu County Medical Society in 1939. He was an enlisted man in the United States Navy during World War I; during World War II, he served with distinction in the Medical Corps of the Navy and was retired with the rank of Captain in the United States Naval Reserve.

Doctor Trexler lived an extremely active life without ostentation, but in his vigorous way contributed much to the world he lived in. He was a wonderful companion with a charming, happy personality, and his laughter and joy of living will survive him. He had a great passion for work and punctuality, and will be missed by his medical colleagues as well as by his friends outside the realm of medicine. He is survived by his devoted and charming wife, Eva Rose, who was his constant companion and great helpmate.

He loved all sports. For several years he played golf and once was the champion of the State and County medical societies. He delighted in recounting this accomplishment. His collection of steins must be one of the finest and largest anywhere. Probably no one enjoyed the game of cribbage as much as he did, and he was rated expert. All of us who have known Clarence Trexler agree that knowing him was an unforgettable experience.

Douglas B. Bell, M.D.
Harold M. Johnson, M.D.
W. J. Holmes, M.D.

DONALD MUNROE WRIGHT, M.D.
1921-1963

When Dr. Donald Munroe Wright died on July 25, 1963, a highly motivated and dedicated colleague was lost. Dr. Wright never lost sight of the physician's primary goal, the care of the patient, and he assiduously aspired to excellence rather than mediocrity in attaining this goal. To those who knew him well, it was quite apparent that he had well-formulated and clearly defined ideas, but always retained an open mind. He will long be remembered for his contributions and meritorious performance in serving his fellow man.

The son of Wade Stanley Wright, M.D., and the grandson of James Harvey Wright, M.D., Dr. Donald Wright was born on February 8, 1921, in Boston, Massachusetts. After preliminary education at Phillips Exeter Academy, New Hampshire, he attended the University of California in Berkeley. From there, he went to Northwestern University School of Medicine, graduating in 1946. Following an internship at Passavant Memorial Hospital in Chicago, he completed an ENT residency at Brooke General Hospital, Ft. Sam Houston, Texas.

Commissioned as a First Lieutenant in the U. S. Army Medical Corps in 1946, he served until July, 1955, at which time he resigned from the service with the rank of Lt. Col., a rank he attained in July, 1951. He served as Assistant Chief and Chief of Otolaryngology at five general hospitals during that period of time.

From 1955 to 1957, he was associated with the Physicians and Surgeons Clinic in Quincy, Illinois, as an otolaryngologist and then in August, 1957, he joined the Straub Clinic serving as an otolaryngologist until his untimely death from bronchogenic carcinoma on July 25, 1963, at The Queen's Hospital.

He was a member of the American Medical Association, Hawaii Medical Association, Honolulu County Medical Society; Hawaii Eye, Ear, Nose and Throat Society; and the American Geriatric Society. He was on the attending staffs at The Queen's Hospital, St. Francis Hospital, and Kauikeolani Children's Hospital, and in addition to serving on several key committees, he took an active part in the training program of the house staffs. He was also a member of Phi Rho Sigma and the alumni associations of Phillips Exeter Academy and Northwestern University. He attended St. Andrew's Cathedral and was a member of the Republican Party of Hawaii.

He is survived by his wife, Claire Carmer Wright, and his sons, Daniel Munro Wright and James Harvey Wright, of Honolulu; his sons Wade Stanley Wright and David Glover Wright of Omaha, Nebraska; his mother, Mrs. Wade S. (Marie) Wright of Ojai, California; his sister, Mrs. Stanley J. (Barbara) Cristol of Boulder, Colorado.

He enjoyed sailing and at one time had been an excellent fencer (foil, epee, and sabre). In the few years preceding his death, he found time for only one hobby, photography, at which he excelled.

Professionally, he had always manifested an interest in hearing problems, especially those of children. He gave unstintingly of his time in a consultant capacity to various medically indigent patients wherever he served, substantiating the old story that the best in men is found in those who strive to help their fellow men.

His funeral service was held in Parke Memorial Chapel, St. Andrew's Cathedral, on July 27, 1963, and interment was at the National Memorial Cemetery of the Pacific on July 29, 1963, with full military honors.

As a man well respected by his colleagues, Dr. Wright will be sorely missed for his conscientious, capable, selfless performance of duties. Our heartfelt sympathies go out to his family, friends, and patients.

H. James Lambert, Jr., M.D.

HAWAII MEDICAL JOURNAL

Notes and News

New Offices

Dr. Betty S. M. Soo, pediatrician, has become associated with the Chock-Pang Clinic at 1374 Nuuanu Ave.

The Medical Specialty Clinic, formerly Chang-Wakai Clinic, has announced the association of **Dr. Willard Y. Miyahira,** internist.

Dr. Theodore K. L. Tseu, obstetrician and gynecologist, is now practicing with Dr. Gail Li at 1523 Kalakaua Ave.

Dr. Frederick E. Popoff, psychiatrist, has located at 1531 So. Beretania St., in the Central Medical Building.

Dr. Norberto Baysa, general practitioner, is practicing at 916 Kilani Ave. in Wahiawa.

The Straub Clinic has announced the association of the following new members to their group: **Drs. Edward L. Chesne,** internist; **Reginald Ho,** internist; **Arthur W. Neilson,** internist; **Truett V. Bennett,** otolaryngologist.

Dr. Edward L. S. Jim, surgeon, has joined his brothers Robert and Vernon in the practice of medicine at the Professional Bldg.

Relocations

Dr. Norman Y. Nakamura, orthopedic surgeon, has joined the parade to 1441 Kapiolani Blvd.

Dr. Cecil A. Saunders has moved his offices to a poolside suite at the Biltmore Hotel.

Welcome

Mr. H. Tom Thorson, Honolulu County Medical Society's new executive secretary, has succeeded Mr. Howard Pearce who resigned to take a position with the Santa Clara Medical Society in California. Fresh from the Okanogan County Medical Society in the State of Washington, his door is open at all times and while he is "feeling" his way around, learning about Honolulu doctors, he invites all to drop in and say hello.

Condolences

To the family of **Dr. Donald Wright,** who died on July 25 of bronchogenic carcinoma.

To the wife and children of **Dr. Joseph Palma,** whose death from pancreatic carcinoma early in August shocked the medical profession. Joe, who was a scholar, raconteur, sportsman, and pediatrician, will be sorely missed by all—especially so at HMA convention time, and especially by the golfers, who anticipated his jovial company at play and at the picnic. His rendition of Sweet Leilani at the annual banquet will be missed and long remembered, as will his active participation in medical matters.

To **Dr. and Mrs. Bernard Yim,** who lost their infant son.

Traveling Doctors

Dr. Walter B. Quisenberry spent five weeks on a lecture tour of Australia and New Zealand.

In Tokyo attending the Japanese Psychiatry and Neurology Society's meeting were **Drs. Dorothy La Fon, William Cody, Robert Browne, Linus Pauling, Jr.,** and **George Schnack.**

Hawaii doctors who registered at the AMA meeting in Atlantic City included **Harry L. Arnold, Jr., Marvin**

continued next page

HAROLD R. McKEEN, JR., M.D.
1908-1963

Dr. Harold R. McKeen, Jr., was born May 6, 1908, in Edith, Colorado, the only son of a practicing physician, Dr. Harold R. McKeen, Sr., and his wife, Maud Bush McKeen. He attended school in Denver and at the University of Colorado until he was admitted to Harvard Medical School, from which he graduated in 1935. His internship was spent at the Denver General Hospital from 1935 to 1937. He then served as Physician-Surgeon with the Public Service Company of Colorado. During this time he also served as Assistant in Surgery at the Colorado General Hospital and on the Fracture Service at the Denver General Hospital.

On June 8, 1940, he married Miss Betty Westhaver of Denver. He spent his honeymoon in Hawaii, at which time he first discovered his fond love for the Islands. From 1942 to 1946 he served as Surgical Ward Surgeon of the 29th General Hospital and saw service as a Battalion Surgeon of the 96th Division in New Caledonia. He participated in the Battles of Biak, Leyte, and Okinawa. In 1946 he was evacuated to Hawaii, when he renewed his desire to live here. He returned to Denver, where he served as Assistant Medical Director of the Public Service Company of Colorado from 1946 to 1954, and as Medical Director from 1954 to 1956.

In 1956 he moved to Hawaii, where he served as Physician-Surgeon of the Waialua Plantation. In 1958 he became associated with the Kaiser Foundation Medical Care Program, where he eventually became a permanent member of the Hawaii Permanente Medical Group and Physician-in-Charge of the Kaiser Foundation Maili Clinic.

He was a member of the Denver Medical Society; Honolulu County Medical Society; Hawaii Medical Association, American Medical Association; and a Fellow of the American College of Surgeons. He was treasurer of the Waianae Businessmen's Association, and also a member of Lion's International and the Maili and Waianae Community Associations.

Dr. McKeen died of coronary heart disease on June 20, 1963, after seeing his last patient of the day at the Maili Clinic, at the age of 54. He is survived by his wife, Betty; his son, Harold, III; and two daughters, Elsbeth and Rebecca.

P. T. Chu, M.D.

A. Brenneeke, Clifford Chock, Robert C. H. Chung, W. W. Goodhue, Henry C. Gotshalk, Frank H. Hatlelid, P. H. Liljestrand, George H. Mills, Richard D. Moore, R. Varian Sloan, Rodney T. West, Arthur K. Wong.

Names in the News

Dr. George H. Mills is one of the 27 local and mainland community leaders on the newly formed Advisory Council for Kamehameha Schools.

Dr. Gail Li was a recent victim of burglars when his home was looted and some $40 taken from coin banks.

Dr. Sidney T. Fujita made the news again, this time very pleasantly, when a civil suit filed against him was dismissed in court. A suit against Paauilo physician **Wilmot Boone** has also been dismissed.

Dr. Richard K. C. Lee was elected president of the Health Facilities Planning Council of Hawaii. **Dr. Edward W. Colby** is the executive director.

Dr. Robert Rose was mentioned as having testified for the defendant in a civil damage suit.

Dr. Joseph C. Finney's comments on Hawaiians made in 1961 was the cause of some admonitions to Hawaiians by the Reverend A. K. Akaka.

Faulty engine wiring was the cause of **Dr. Joseph T. Y. Kam's** car fire recently as he was leaving St. Francis Hospital.

The announcement of **Dr. Edward L. S. Jim's** joining brothers Vernon and Robert in the practice of medicine caused quite a stir because of its unusualness. A *Star-Bulletin* reporter then "dug up" family doctor teams. Mentioned were the **Bell brothers, John** and **Douglas,** and **Douglas II. Dr. I. Katsuki** and his three sons, **Drs. David, Sanford,** and **Robert.** The **Yous, Richard** and **Estridge.** The **Lams, Fred, Sr.** and **Fred, Jr.** The **Lichters, Martin** and **Rowlin.** Brothers **F. J.** and **O. D. Pinkerton. Henry** and his sister, **Corazon, Manayan.** The **Arnolds, Sr.** and **Jr.** The **Nishijimas, Satoru** and **Randal.** The **Boone** brothers, **Edward** and **Wilmot,** Brothers **Robert T.** and **James T. S. Wong, Homer** and **Robert Benson, H. Q.** and **L. Q. Pang.** Fathers and sons **Min Hin** and **Gail Li, Joseph** and **Walter Strode, Richard** and **Calvin Sia, L. L.** and **Harold Sexton.** The **Mirikitani** brothers, **Clifford, Carl,** and **Isami.**

Dr. Ralph B. Cloward's surgical treatment of traumatic central spine syndromes which appeared in *Reconstructive Surgery and Traumatology* (October 7, 1963) will be reproduced in the *Insurance Counsel Journal,* a publication devoted to legal and medical articles which are of interest and concern to trial lawyers who represent insurance companies in personal injury and casualty insurance fields.

The wedding of **Dr. Robert C. Lee, Jr.,** son of **Dr.** and **Mrs. Robert H. Lee,** was the cause of much socializing recently.

Congratulations to . . .

Dr. Paul Y. Tamura, recent recipient of the Professional Education award of the American Cancer Society, Hawaii Division.

Dr. Robert B. Faus, for being honored at the Athletic Banquet of the University of Hawaii. Bob served the University from 1926 to 1940 as football team physician.

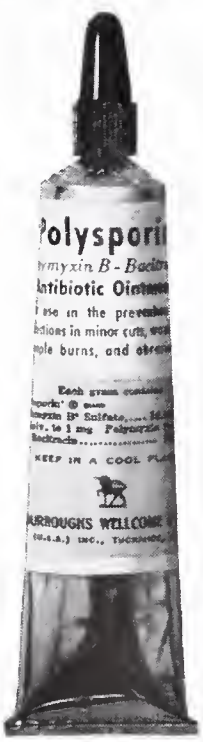
Dr. William J. Holmes, who was elected President of the Friends of the East-West Center, at its annual meeting.

Dr. Alvin V. Majoska, who was awarded the 10th Annual Award for Clinical Investigation by the American Academy of Registered Criminologists.

Dr. Fred K. Lam, who was informed in July that he was to receive the Alumni Merit Award for 1963 from the St. Louis University during its Founders Week Pro-

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in treating topical infections, no need to sensitize the patient



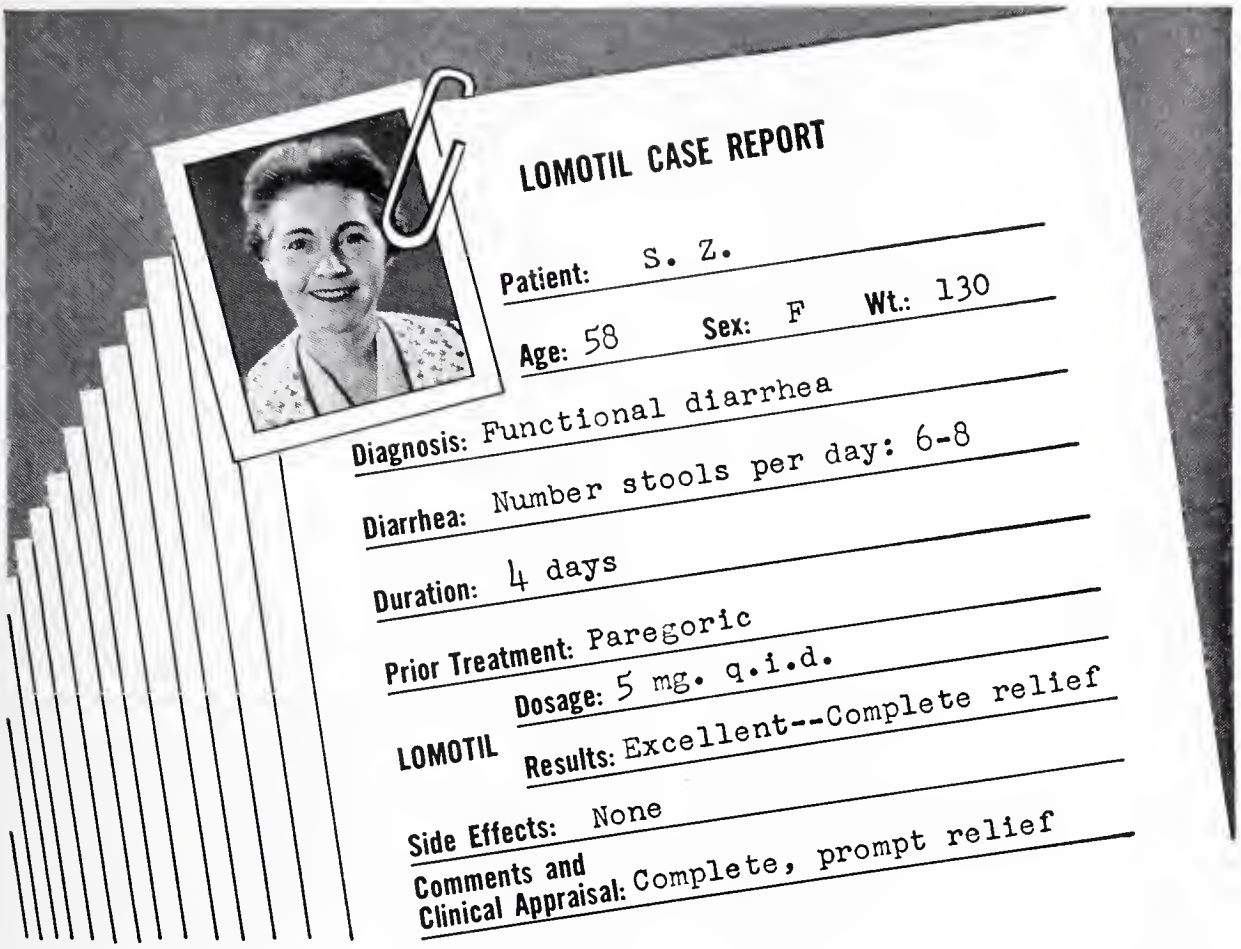
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Numerous investigators have remarked on the effectiveness of Lomotil in patients with diarrhea uncontrolled by other agents.

Weingarten and his associates[1] found it "an excellent drug . . . efficacious where other drugs have failed. . . ."

Hock[2] obtained "results superior to prior medications in 68.3 per cent of 41 patients."

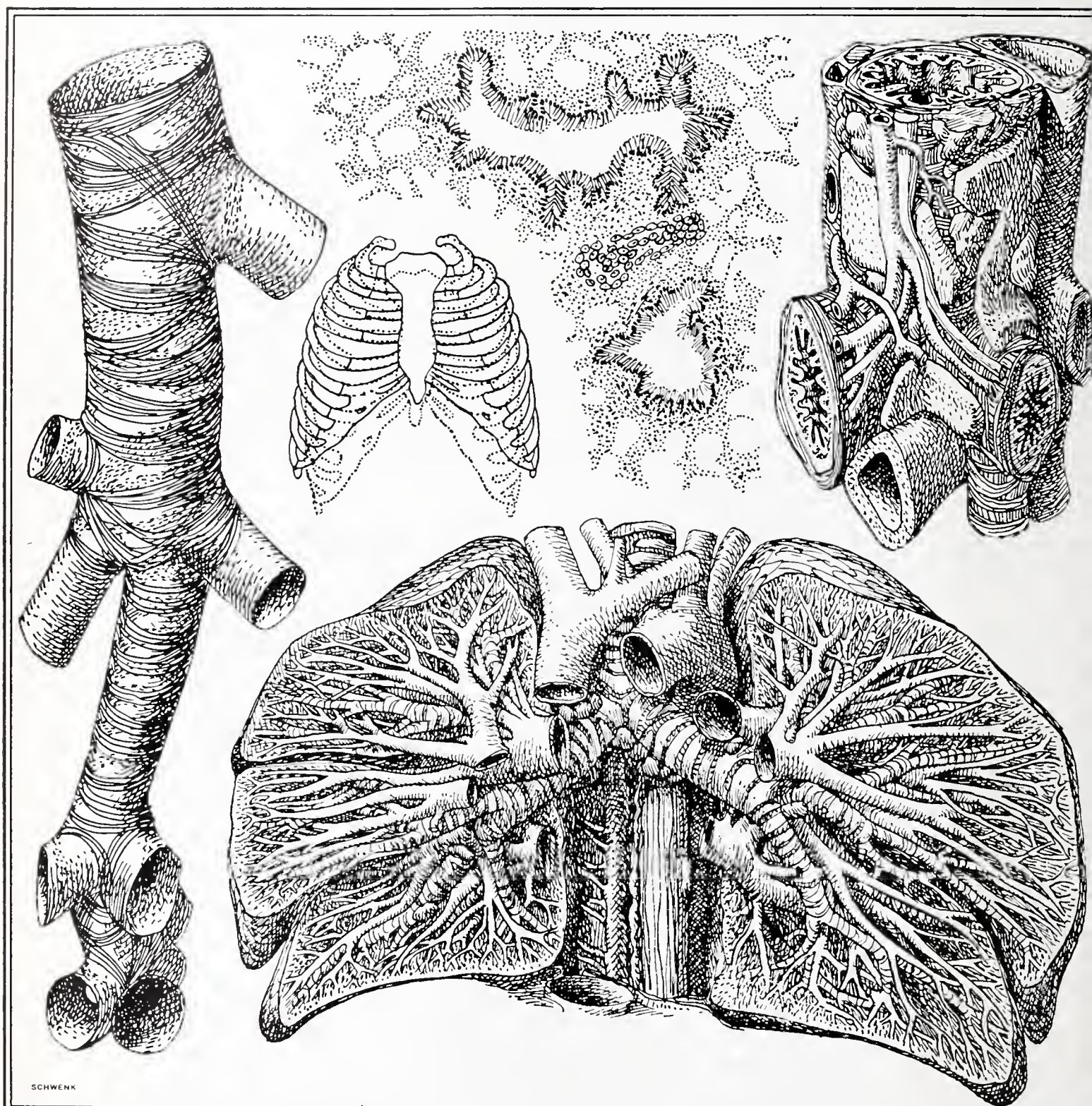
Since Lomotil controls diarrhea so consistently, it is only rational to prescribe Lomotil *before* other agents have a chance to prove inadequate. To control diarrhea promptly, prescribe Lomotil promptly.

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1. Weingorten, B.; Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiorrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961. 2. Hack, C. W.: Relief of Diarrhea with Diphenoxylate Hydrochloride (Lomotil), J. Med. Ass. Georgia 50:485-488 (Oct.) 1961.

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: JAMES YANO, Kaiser Foundation Hospital

ASMT Convention Report

"Focus on the Future" was the theme of the 31st Annual Convention of the American Society of Medical Technologists held in Denver, June 16-21. With headquarters at the Hilton Hotel, the entire program from the onset was well planned. It was a gratifying experience for me to be a part of this huge convention, involving 1,500 delegates from all parts of the United States, Canada, Alaska, and other countries.

I boarded the United Airlines Jetliner at 11:30 P.M. on June 14, after a nice aloha send-off by members of the HSMT. Due to a fortunate miscalculation on the part of the reservation department, I was given a royal treat and flew first-class at tourist rates. After a 45-minute stopover in San Francisco, we proceeded on to Denver. By noon that same day, I was settled at the beautiful Hilton Hotel, with a lovely view of the city.

At Convention registration, in addition to the program, each of the delegates were supplied a carrying kit by Hyland Laboratories with several souvenir pebbles of Denver enclosed.

LEGAL MATTERS

The Advisory Council met at 9:00 the following morning in the spacious Junior Ballroom. Mr. John Sembower, ASMT Legal Counsel, reported that the $1,000,000 suit filed against the Ohio Society of Pathologists and Medical Technologists and the $750,000 suit filed against the publication *Modern Hospital* were dropped by the Carnegie Institute on agreement of both parties. Still pending, however, is the $250,000 suit filed against the National Committee for Careers in Medical Technology, Washington, D. C., and its executive secretary, Mr. Dallas Johnson. The Ohio State Society representative, Mr. Conrad Bogusz, questioned the action of the board members since the proposal they had signed stipulated that all suits against the ASMT would be dropped altogether. The legal counsel clarified the matter with the following explanation: when Carnegie Institute filed the suits against the Ohio State Society, *Modern Hospital,* and the NCCMT, the counselors from each organization agreed to work separately and at no time confer with each other nor to put into action any proposals harmful to each other. Let us hope that the last of the pending suits will also be dropped in the near future by mutual agreement and that no other similar suits will be filed against the ASMT.

REPORTS AND RECEPTIONS

The next business was the Standing and Special Committee reports, which appeared in the April and June issues of the *Micro and Macro News.* Presentations of various resolutions from the state societies followed. The Advisory Council deferred the matter of electing its chairman.

At the President's reception, that evening, I met many wonderful delegates from different state societies. Lavina White, Past President of ASMT, served as Honorary Chairman of the opening session and she presented Mary Kellogg, General Chairman of the convention; Harold D. Palmer, President of the American Society of Clinical Pathologists; Lenna Loyd, President of the ASMT; and Ellen Swanson, President of the Colorado State Society of Medical Technologists.

The Texas State Society gave a Hospitality Party to promote their theme of "Houston in 1968," the convention site of the 1968 Annual ASMT Convention. Cowboys and cowgirls, all dressed in their gay western outfits added local color to this night of festivities. When the Texans stopped their hooting and hollering at about 9:00 P.M. the setting was just right for the climax of the evening with champagne and music at the Scientific Products suite. One would wonder how any delegate could withstand the temptation of fine liquors and champagne in order to last the entire evening in a sober condition, but I did, and so did the good sisters. I took my ginger ale straight while the sisters took their coffee straight.

CONFERENCES, SCIENTIFIC SESSIONS, AND TOURS

The formal opening of the 1963 Convention began the next morning with the greetings by the president of ASMT, Lenna Loyd, followed by the invocations by Rabbi C. E. Hillel Kauvar. After the ceremony of the Presentation of the Colors by the U. S. Air Force Academy Squadron and several speeches by dignitaries, the keynote speaker, Oliver K. Niess, M.D., Surgeon General, U. S. Air Force, presented his talk, "Focus on the Future." He stressed the fact that physicians and technologists will work together to safeguard the health of future space crews. In regard to automation, he said, "More and better machines can lighten the load and improve the product, but the medical technologists will always be the most important factor in insuring accuracy and dependability." He emphasized the idea that dedication and research should be our goals.

C. G. Schmidt, President of the Scientific Products Foundation, officially opened the scientific and technical exhibits. There were 94 exhibits in all, many of them very interesting and fascinating. Only wished we had more time to scrutinize them and digest the essential concepts and techniques.

Tuesday morning I listened to the presentations of three scientific papers: first, electron microscopy in biology and medicine; second, the detailed study of the electronic Coulter cell counter by Elizabeth Pruden and Martha Winsted; and third, a new medium for hemoglobin electrophoresis by Jo Cronenburger. We later heard Mr. Scott Werner give an interesting and intriguing account of the "History and Jurisdiction of the FBI in Matters Relating to the Laboratory."

A tour of the Air Force Academy, Colorado Springs, scenic Garden of Gods, and the Flying "W" Ranch was on schedule for that afternoon. The cumulus clouds up in Denver must have heard that a Hawaiian boy was among the 700 delegates taking the tour because he was greeted with a real Rocky Mountain thunder storm. The huge "golf ball" like hailstones which fell in other parts of Colorado caused some property damage. Because of the adverse weather conditions, the tour of the Air Academy was very brief; however, when we arrived at the Flying "W" Ranch to feast on a real chuck wagon dinner, the storm lifted and the weather cleared. The most streamlined chow line imaginable served dinner to 700 delegates in less than 10 minutes, demonstrating a new era of automation of food service. Brrr, was it cold up there in the high lands. The hot cup of coffee in the tin cup was a lifesaver for me, especially. We had a most enjoyable evening with entertainment by top Western performers. When we returned to the hotel we were thoroughly exhausted and our voices were hoarse from singing all of the way back.

I spent all Wednesday attending committee conferences—the Recruitment Committee Conference, the Standards and Studies Committee Conference, and the Constitution and Bylaws Committee Conference, and listening to stimulating speakers, such as Harry W. Toll on "Problems of Medical-Legal Significance," a symposium on automation and its effect on the future of medical technology moderated by Alexis E. Lubchenco, M.D.; to Dr. David Seligson on "How Much Automation for the Clinical Laboratory," and last but not least, to Dr. Walton H. Marsh on "Perspectives in Automation."

The lecture by Dr. R. D. Gafford on the "Fully Regenerative Life Support Systems for Advanced Man Space Operation" the following morning was very informative.

HOUSE OF DELEGATES

Wednesday afternoon at 1:00, the House of Delegates convened. Four major resolutions were passed: (1) The Massachusetts resolution to establish as of 1967 minimum requirements of three years of schooling in an accredited college or university, graduation from an approved hospital school of medical technology, and a baccalaureate degree in order to qualify for the M.T. (ASCP) Registry examination. (2) The Detroit resolution proposed that each individual state be given the prerogative to consent or not to consent to a laboratory assistants' program. An amendment to the constitution was passed whereby copies of minutes at the meetings be also available to the Advisory Council members. (3) An Ohio resolution directed the Public Relations Committee to investigate the cost of having an exhibit on Medical Technology at the Smithsonian Institute and expenses inherent in the transportation of the said exhibit, as well as future maintenance costs. They are to have a report available to the 1964 House of Delegates. (4) The Oregon resolution proposed to review and rewrite the Constitution and Bylaws for the purpose of formulating efficient tools of operation.

The ASMT officers elected for 1963-64 were Annie Laurie Peeler, President; Jeanne L. Schlafman, President-elect; Kathern B. Forest, Recording Secretary; C. Patton Steele, Treasurer; Mary Ann Kellogg, Helen J. Madden, and Isabelle Havens, Board of Directors.

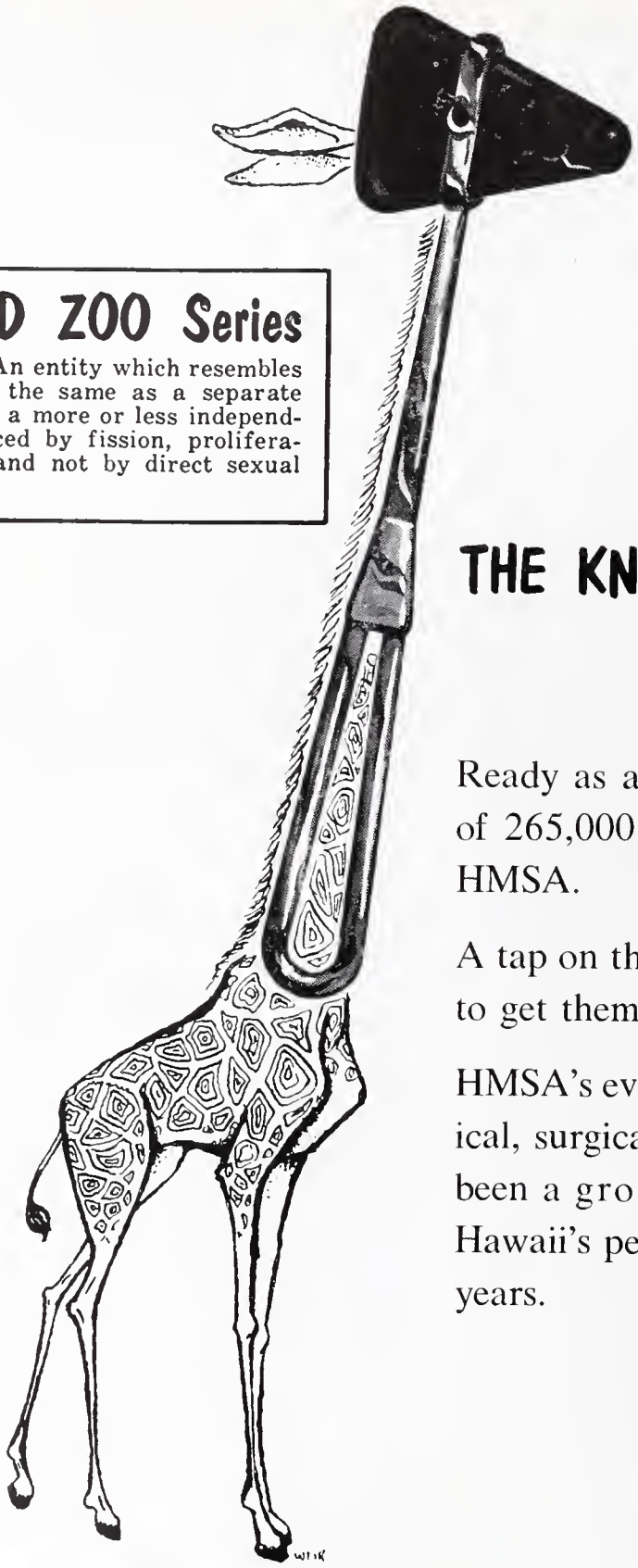
AWARDS BANQUET

The highlight of the entire convention was the Awards Banquet. Not only was the dinner delectable but the entire ceremony was very impressive. C. Patton Steele won the Corning Glass Award as the most outstanding medical technologist for 1963. Elizabeth Pruden and Martha Winsted won four awards with their detailed work on the Coulter cell counter—the first prizes in hematology, in educational and procedural studies, Registry of the ASCP, and third place award by ASMT. "Comparison of the Media for the Production of Chlamydospores" by Jocelyn Duncan won her the Scientific Products Foundation Microbiology award. Other winners included Carol Nelson, biochemistry; Regina M. Guzak, biochemistry; Hannah Presthold, blood banking; Lee Luna, histology.

It would be gratifying to see an award winner from Hawaii with a paper contributing to science and to medical technology. Incidentally, we can be proud of Ann Stegmaier of our own HSMT who received a certificate from the Corning Glass Company for being the outstanding medical technologist of Hawaii for 1963.

I would like to thank the members of the Honolulu Society of Medical Technologists for sending me to the convention to represent Hawaii. I wish more of you could have attended this memorable 1963 Convention. May I add that I will do my best in carrying out the duties and responsibilities as your president and in return would like to ask for your full support in any and all undertakings of our Honolulu Society of Medical Technologists.

JACK FURUTA, MT (ASCP)
President



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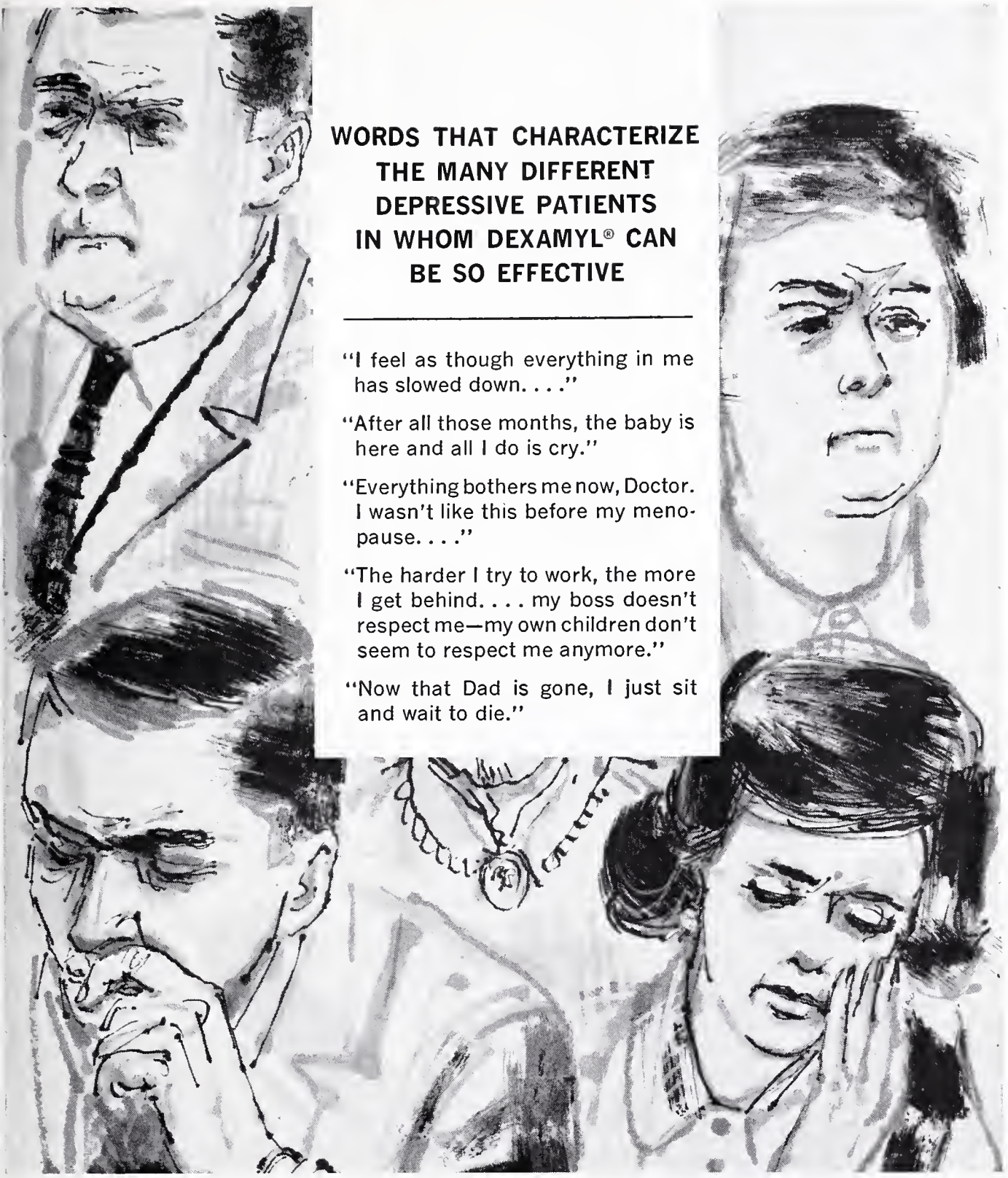
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In Memoriam *continued from 48*

rado, from which he received his M.D. degree in 1912. The kindness of the people in Colorado moved Dr. Ochiai to write that they "inspired me with the true meaning of Christianity."

Returning to Honolulu immediately after graduation, Dr. Ochiai opened an office for the general practice of medicine.

In April, 1916, he married Waki Sakamoto. They became the parents of two children, Mei and Ko.

Due to illness, Dr. Ochiai gave up his practice and with his family sailed for Yokohama in October, 1918. On October 17, 1918, he died in Yokohama at the age of 36. ■

County Society News *continued from 53*

cooperation. Dr. Schnack invited the doctors to attend the forthcoming Mental Health Conference.

Dr. Noboru Oishi introduced the guest panelists who spoke on "The Three Party System" — doctor, patient/client, and insurer. Dr. Hunter gave a progress report on the fee survey questionnaire returns. A summary of union complaints received through the HMSA was placed on file as circulated.

Kauai

There was no meeting held in July.

Guests at the August 6 meeting included Drs. Joseph Stokes, III, Respecio, and Cruz.

Letters relative to the recent election of the HMA president-elect received from Hawaii, Maui, and Honolulu medical societies were circulated. As there had been no further communications from either the HMA or Honolulu County, the matter was tabled until communications are received. Dr. Wade reported on the last Council meeting and advised that there would be an interim meeting of the House of Delegates in September.

Dr. Goodhue reported on the activities of the HMA Public Relations Committee including the proposal of either sending someone from Kauai to Honolulu or having someone from Honolulu attend the Kauai meetings. It was decided to write to each neighbor island county to determine their preference. It was agreed to determine the number of Message of the Month flyers the Kauai doctors would need. It was also agreed to participate in "Operation Hometown."

The Society voted to approve and cooperate with the Assistant Medical Practitioners and Nurses of the South Pacific Program. It was voted to approve an amendment to the HMSA contract which would permit the HMSA to report irregular billings to the county societies. It was voted to change the first meeting in September to Wednesday in order to accommodate the visit of Mr. Aubrey Bates of the AMA.

The Board of Medical Examiners' offer to purchase $166 worth of books was accepted. These will be divided among Dr. Wade, Samuel Mahelona, and Wilcox Hospital libraries. Dr. Kim offered to make his copy of the directory of congenital defect centers available to the G. N. Wilcox Library. A second copy will be kept at the Kauai Veterans' Hospital Library.

Dr. Kim reported on the diabetic instruction program being developed with the public health nurses. A detection Clinic will be held in November. The meeting ended with a talk by Dr. Joseph Stokes, III, on the use of antibiotics. ■

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Reports & Snorts

Galen didn't have the last word. Know what you'd get by mixing (hang on tight, now!) polyoxyethylene sorbitan monostearate, alcohol (ethyl, I suppose), thimerosal, aluminum hydroxide gel, titanium dioxide, glyceryl monostearate, polyethylene glycol monostearate, silica, silicone fluid, propylene glycol, ethylenediamine, hydrochloric acid, white petrolatum, polyoxyethylene fatty alcohol ether, methylparaben, propylparaben, sorbitol solution, triamcinolone acetonide, neomycin sulfate, gramicidin, and nystatin—in the right proportions? Probably a slightly gooey mess; but if you also did it in just the right *way*, what you'd get wouldn't be a Baby Ruth bar, as you might think. It would be Mycolog cream!

• • •

Radio-autographic photomicrographs of cancer cells, made with tritium-labelled thymidine in the chromosomes, have shown that cancers do not grow rapidly because of frequent mitosis—cancer cells divide at longer, often much longer, intervals than normal cells do. They grow rapidly because every cell resulting from a mitotic division is able to undergo mitosis, and does so. In normal tissue, only one of each pair of daughter cells retains the ability to undergo mitosis.

• • •

The FDA proposes to "halt certification"—which we suppose means forbid the manufacture or sale—of systemic oral drugs that contain an antibiotic in combination with such medications as analgesics, antihistaminics, and decongestants, on the perfectly sound ground that antibiotics are no good for colds or other upper respiratory viral infections, nor for the prevention of bacterial complications of the same.

• • •

Tarzan's last words as heard from a treetop: "Who greased the vi-i-i-i-ine?"

• • •

The W. B. Saunders 75th Anniversary Writing Fellowship Award has been awarded to two recipients instead of one, as planned. Two equal fellowships, each in the amount of $15,000, have been granted to Dr. Herman M. Kalckar of Harvard and Dr. Paul B. Beeson of Yale. And though they have done nothing so crass as to suggest that we mention it, the new edition of Cecil and Loeb is out with some brand new articles in it: for instance, Diseases of Joints has been completely rewritten by William D. Robinson of the University of Michigan—the first time Dr. Cecil has let it out of his own hands.

• • •

Know what Macbeth said when Birnam Wood came to Dunsinane? "Cheese it—the copse!"

Some words have unexpected plurals. Two octopuses are not two "octopi," but two "octopodes." Avoid them! And more than one decubitus is just two or three "decubitus"—not decubiti. You should not be surprised, however, to know that the plural of diverticulum is diverticula, not diverticuli. All Latin words with -um endings form the plural with -a.

• • •

Diabinese (chlorpropamide, Pfizer) is contraindicated in pregnancy, says an August 21 announcement. The reasons are so involved they are intriguing: (1) diabetes in women of childbearing age is usually not of the stable, maturity-onset type; (2) Pfizer is "unaware of significant, reliable data on the use of chlorpropamide during pregnancy"—a lack blamed on the fact that "sulfonylurea therapy of diabetes during pregnancy is contrary to the advice and recommendations of the general consensus of expert opinion on this subject." What this *means in turn is that pregnancy is regarded as complication of diabetes and therefore an indication for insulin. So its use is inadvisable because it's been inadvisable all along!*

• • •

Dr. Hampton R. Bates, Jr., of Richmond, Virginia, suggests in *JAMA* that the readability of medical periodicals can be assessed quickly by determining their titles containing the word RI (Rat Index). The number of rats (or guinea pigs, or hamsters, or other equivalent) in the table of contents is divided by the total number of articles, and the result expressed as a decimal index to two significant figures. An index of 0.40 suggests an issue that would be enjoyable for a man of highly scientific bent; the more clinically oriented reader would find an issue with an RI of about 0.02 more to his liking.

• • •

The way to know that something might happen is to know that once, somewhere, it *did* happen. The way to know that fluoridated drinking water might be harmful would be to know that somewhere, once upon a time, it *was* harmful to someone. Dr. Frederick Exner of Seattle had a couple of weeks in a Federal court in which to prove this—and he couldn't do it. The reason he couldn't do it is because it hasn't ever happened—not once, so far as available evidence goes, which is pretty damn far, after some 15 years. Fluoride poisoning has occurred from naturally fluoridated water—but never from artificially fluoridated. All Honolulu's Pure Water Association is really accomplishing is continuing malnutrition for Honolulu's children, who are compelled to drink fluoride-deficient water and can only build soft, vulnerable teeth as a result. ■

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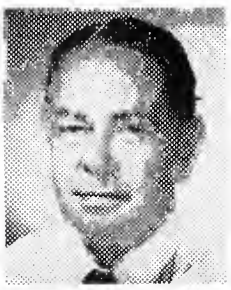
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cause of conflict with their bounty's bylaws and to write a letter to Honolulu County stating the problem.

It was voted to write official letters to the members whose membership dues are delinquent and to make personal contacts when necessary.

It was voted to extend delinquency date for Drs. Herman Kramer and Mor J. McCarthy as requested.

It was voted to advise Dr. Mor J. McCarthy that a transfer of funds from the PBF account to his dues account cannot be accomplished.

It was voted to send the usual letter to the members who are delinquent in their legislative assessment.

TREASURER'S REPORT

The Treasurer's report was reviewed item by item. Dr. Chinn commented on the change of auditors. He advised that he had checked into this with several people, including a retired CPA who is also a lawyer. The firm of Leong and Leong had been suggested as being both reliable and reasonable. He asked for suggestions for other CPA's. Professional ethics and competitive bids were discussed.

Dr. Chinn explained the changes brought about by the establishment of a new fiscal year and the resulting short accounting period.

Dr. Chinn called attention to the request of the Medical Care Plans & Fees Committee for an allotment to cover their dinner expense. He asked for some standards to go by for determining whether payment should be authorized for meals served at committee meetings. Dr. West said this committee worked long hours. He thought consideration should be given to the number of hours, which are over and above the usual time spent in meetings. It was suggested that the Finance Committee take over the expenditure of funds for meals.

Dr. Allison spoke in favor of more Council meetings. The collection of dues was discussed, and the possibility of accepting promissory notes was outlined. It was agreed that the budget should be reviewed by an accountant.

ACTION:

It was voted to establish a Finance Committee as recommended and to empower it to check with the Honolulu County Medical Society to see if there is any possibility of an amalgamation of accounting systems.

It was voted to allow the Finance Committee to pick a new auditor.

It was voted to recommend elimination of the proposed Hospitality Room at the AMA.

It was voted to commend the Careers Committee and to recommend reduction of their budget to the amount originally allocated, $370.

It was voted to recommend that the budgets for the annual dinner for legislators and for legislative entertainment be combined and reduced to a total of $1,000, giving the Legislative Committee the option of making the decision on how the money is to be spent.

It was voted to recommend reduction of the allotment for legislative mailings to $150.

It was voted to combine the Legislative Committee's miscellaneous and unassigned allocations and reduce the figure to $250.

It was voted to give Dr. George Goto a vote of thanks for getting the confidential information bill through the Legislature.

It was voted to put the allocation for additional staff under the jurisdiction of the Finance Committee.

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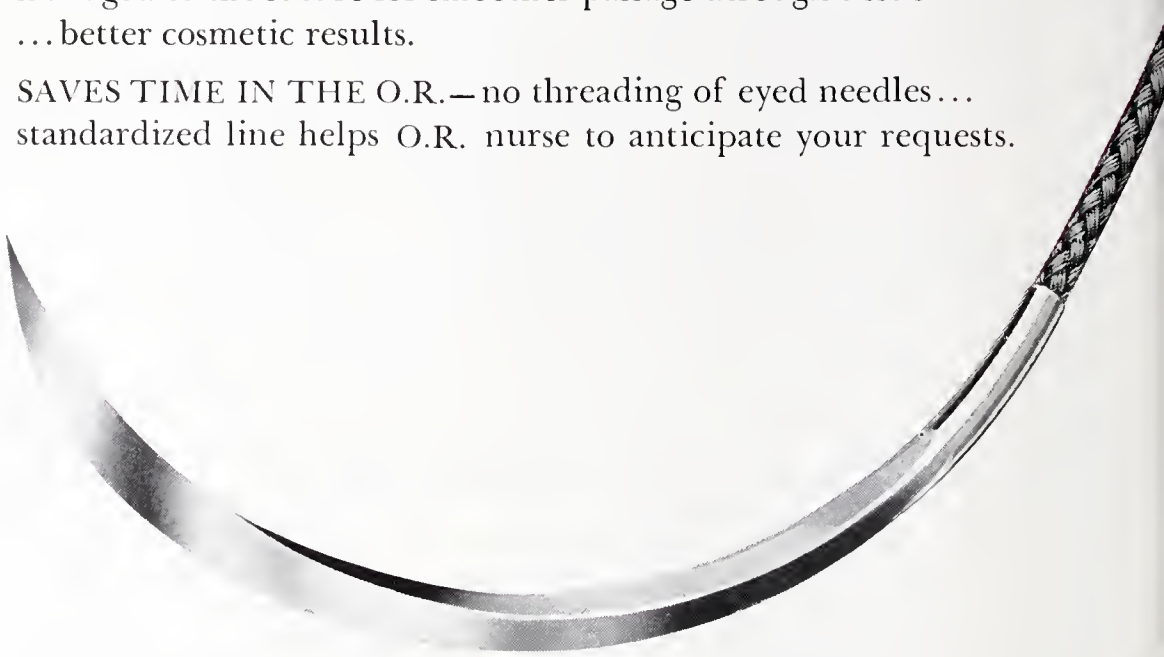
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EVALUATION OF HEALTH INSURANCE POLICIES

A draft of a proposed letter to labor unions, the Employers Council, various Chambers of Commerce, etc., offering the Association's services in evaluating health insurance policies, was circulated. Mr. Thorson advised that he had met with representatives of different labor unions that morning.

ACTION:

It was voted to send out the letter as proposed.

NORTHWEST NATIONAL LIFE INSURANCE COMPANY

The Council was advised of Northwest's proposal to circularize the doctors to try to set up a group term insurance plan for them which could be converted to a policy that would develop a cash value, regardless of the policy holder's insurability. All the company asked was sanction from the Association to make the offer.

ACTION:

It was voted to grant approval as requested.

REPORTS OF SPECIAL AND STANDING COMMITTEES

It was noted that no reports were received.

MALPRACTICE INSURANCE

The attempts to secure group malpractice insurance for the Association were outlined. The latest contact was with Liberty Mutual Insurance Company, the company that covers members of the American College of Physicians and their associates at considerably reduced premiums. Liberty Mutual's underwriters advised that they could not extend this coverage to the entire membership. The Executive Secretary was asked to try to determine the malpractice experience in the State.

MEDICARE CONTRACT

The Federal Medical Services Committee asked the Council to grant the President permission to sign the new contract after it is reviewed by the committee. There are no fee negotiations planned prior to execution of the contract.

ACTION:

It was voted to accept the Federal Medical Services Committee's recommendation.

COMMITTEE ORGANIZATION

Dr. Allison spoke of the difficulty the Association President has in keeping track of all the committee activities and said he felt he needed help. He thought that division of some of the supervisory work among the Council members would not only help the President but would make the Council more effective. He compared this with the division of duties of the reference committees of the House of Delegates. He felt the Councilors should be more active. He also felt that in between sessions there should be an executive committee to go to for help.

Dr. Allison spoke of the necessity for establishing better liaison with the Honolulu County Medical Society in order to obviate problems such as recently arose with the Medical Care Plans and Fees Committee chairman. He told of the events which took place at the Honolulu Board of Governor's meeting where unilateral plans

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were made. He asked the four members of the Council who are also members of the Board of Governors for suggestions. Dr. West spoke of the proposed plans of the Public Relations Committee which has asked the county president to advise it how to establish better communications; whether this can be done better by inviting neighbor island members to meetings or by sending representatives to the neighbor islands. The neighbor island members present felt it would be more effective to send someone to visit them.

NEW COMMITTEES

Dr. West advised that he was in the process of appointing new committees as follows: Liaison with the University of Hawaii's study of a proposed medical school; Association of Religion and Medicine; Pharmacy; Interprofessional Relations. He advised that the head of AMA's Field Service Division, Mr. Aubrey Gates, would be in Hawaii the first week in September and expressed the hope that the neighbor island societies could schedule meetings at that time.

The meeting adjourned at 10:50 p.m.

RANDAL A. NISHIJIMA, M.D., Secretary

Notes and News *continued from 56*

gram scheduled for October 17 to 22. He and Mrs. Lam will pick up the award and then continue to Europe where their itinerary includes a trip to Russia.

Special Congratulations

To **Mrs. P. Howard Liljestrand** who has been elected Secretary of the Woman's Auxiliary to the American Medical Association. She is the first woman from Hawaii to serve on the national board.

Coming Events

Pan-Pacific Surgical Conference, November 5-13, 1963. **Dr. F. J. Pinkerton,** Director General. Local physicians to head discussion sections include **Joseph Strode,** general surgery; **K. S. Tom,** obstetrics and gynecology; **L. Q. Pang,** otolaryngology; **F. J. Pinkerton,** ophthalmology; **William Gulledge,** orthopedics; **Walter Strode,** urology; **Thomas Bennett,** neuro-surgery; **Richard D. Moore,** radiology; **Clifford Chock,** anesthesiology; **Morton Mack,** plastic surgery.

Hawaii Heart Association has scheduled special cardiological sessions for October 31 to November 2, following the 17th Annual Meeting of the American Heart Association in Los Angeles.

The Medical Section of the American Thoracic Society and the National Tuberculosis Association will be held in New York City, May 25 to 27, 1964. Papers are welcome and will be selected from abstracts submitted before January 6, 1964. For details write to Robert Oseasohn, M.D., 1790 Broadway, New York 19.

The First Annual Postgraduate Seminar in Anesthesiology will be held in Miami Beach, Florida, January 5 to 8, 1964. For details write Frank Moya, M.D., University of Miami School of Medicine, Jackson Memorial Hospital, Miami 36.

New Film

The Department of Health has a new film, "PKU, Mental Deficiency is Preventable" suitable for general

continued page 74

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Notes and News *continued from 73*

practitioners, pediatricians, and laboratory technicians. It outlines the several techniques for PKU screening which are now readily available to the practitioner including Phenistix, ferric chloride, 204 dinitrophenylhydrazine, bacterial inhibition, and quantitative plasma analysis.

Every infant should have a routine test for PKU. The film has been placed on loan by the Hawaii Association to Help Retarded Children and is available through your district Health Department office.

Available

Fellowships—University of California School of Public Health to prepare specialists in maternal and child health leading to MPH. For information write Helen M. Wallace, M.D. University of California School of Public Health, Earl Warren Hall, Berkeley 4, Calif.

Hawaii Doctors in Print

Drs. Robert T. S. Jim and **Francis K. Chu** collaborated on an article entitled "Hyperbilirubinemia Due to Glucose-6-phosphate Dehydrogenase Deficiency in a Newborn Chinese Infant," which appeared in the June, 1963, issue of *Pediatrics*.

Dr. C. C. McCorriston's article, "Nonobstetrical Abdominal Surgery During Pregnancy," appeared in the July 1, 1963, issue *American Journal of Obstetrics & Gynecology*." In the same issue **Dr. Frank C. Spencer** and Douglas Yamamura, Ph.D., reported on "Cytologic Survey for Squamous Cancer of the Cervix in Honolulu, 1949-1962."

"Heat Exchanger for a Commercial Disc Oxygenator" was the title of the article written by **Paul W. Gebauer** and Mary R. Connor, B.S., M.T., appearing in the *Journal of Thoracic and Cardiovascular Surgery* in May, 1963.

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Congenital Defects Center

The Congenital Defects Center at Kauikeolani Children's Hospital was officially opened at 10:30 a.m., September 9, 1963. The Center's goal is to provide the entire state of Hawaii with the best care known to modern medicine for children born with birth defects, and to help the families of these children understand and meet the problems arising from these conditions. The areas of greatest unmet need in this State, inborn errors of metabolism and the genitourinary and gastrointestinal tract anomalies, will be concentrated upon.

Patients will be accepted on direct physician referral only and will be charged on the basis of their ability to pay for the services needed.

For further information call or write Donald Char, M.D., Acting Director. ■

Book Reviews *continued from 50*

marized for ready referral. Diagrams and electrocardiograms are numerous, easily understood, and well illustrate most of the subjects. The text itself is readable and clear.

In summary, this book is a good reference text for those interested in cardiology and cardiac arrhythmias and could be helpful to any physician in a particular problem of an arrhythmia.

DOUGLAS B. BELL II, M.D.

Results of Surgery for Peptic Ulcer: A Cooperative Study of Twelve Veterans Administration Hospitals

Edited by R. W. Postlethwait, M.D., Associate Editor James C. Thoroughman, M.D., 308 pp., $8.00. W. B. Saunders Co., 1963.

THIS VERY CONDENSED book discusses results of surgery for peptic ulcer. It should be of interest to all engaged in the surgical treatment of these conditions. A total of 2,977 operations for benign gastroduodenal ulcers are analyzed as to indications for operation, type of operation used, complications, and deaths. The study includes patients operated upon in 1947 and the subsequent ten years. Hence, all patients have been followed at least two years, and a fairly large group for five years or longer. These statistics, therefore, are based on sufficient numbers and length of observation to be of significance. They also give a cross section of the results being obtained by the majority of surgeons doing this type of work, since the vast majority of the operations were under supervision by the senior house staff.

The conclusions reached are based on clinical results on human beings and not on the experimental animal—a refreshing experience, in the light of most current literature on surgical subjects!

There are two points on which I am in disagreement with the authors: First, I do not believe that peptic ulcer is good nomenclature, for it suggests that ulcerating lesions of the stomach and duodenum are of similar origin and require similar treatment, which is far from true; and second, I do not believe that the indication for surgery in gastric ulcers is dependent upon their complications. They respond poorly to medical treatment, and they are always potentially malignant. It reminds me of treating a tumor of the breast, expectantly, waiting to see if metastasis will develop.

In spite of the title of the book being "Results of Surgery for Peptic Ulcer," it is, in my opinion, a valuable contribution to a subject about which so much controversy still exists.

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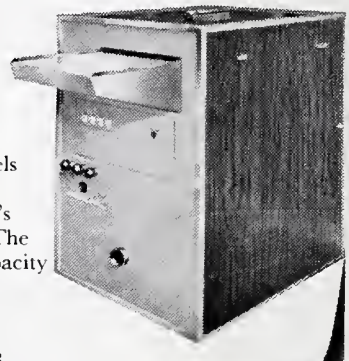
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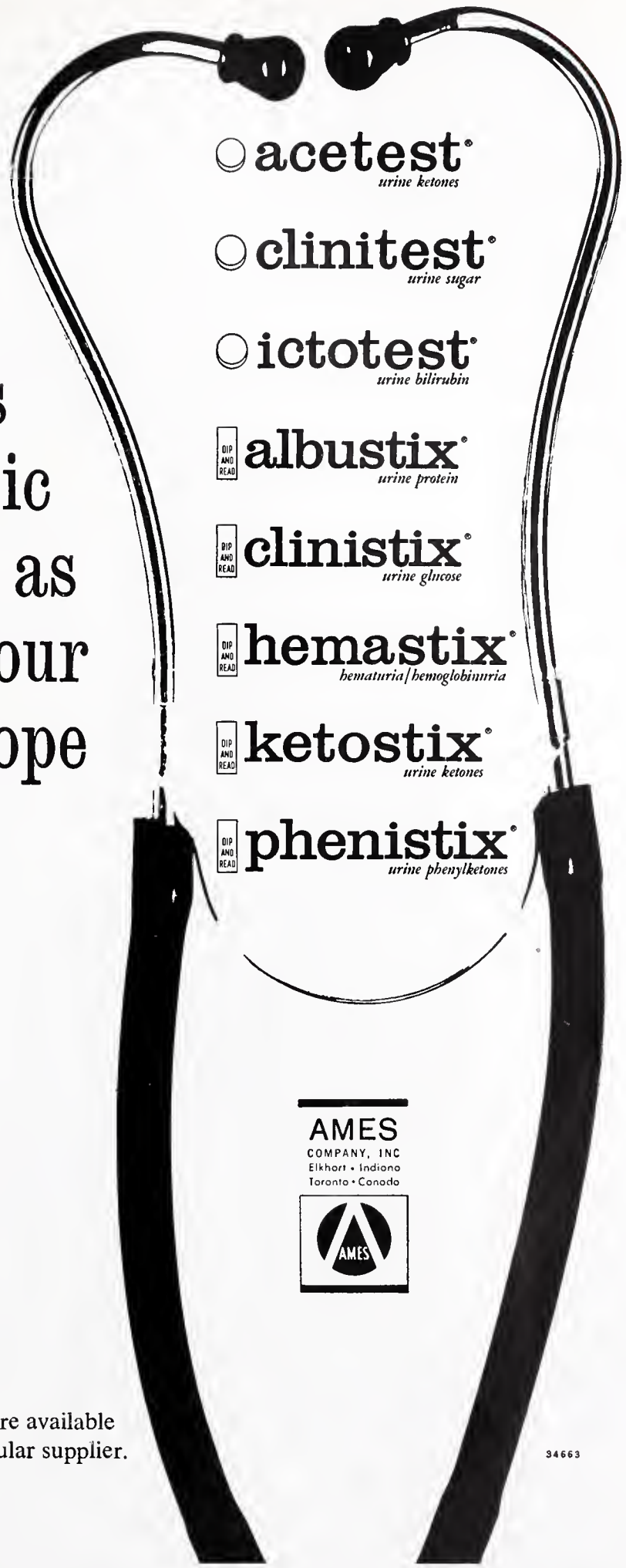
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*Transatlantic Telephone Symposium, *The Effect of Estrogens in the Menopause*, Amsterdam/New York, 1959. Transcript available on request.



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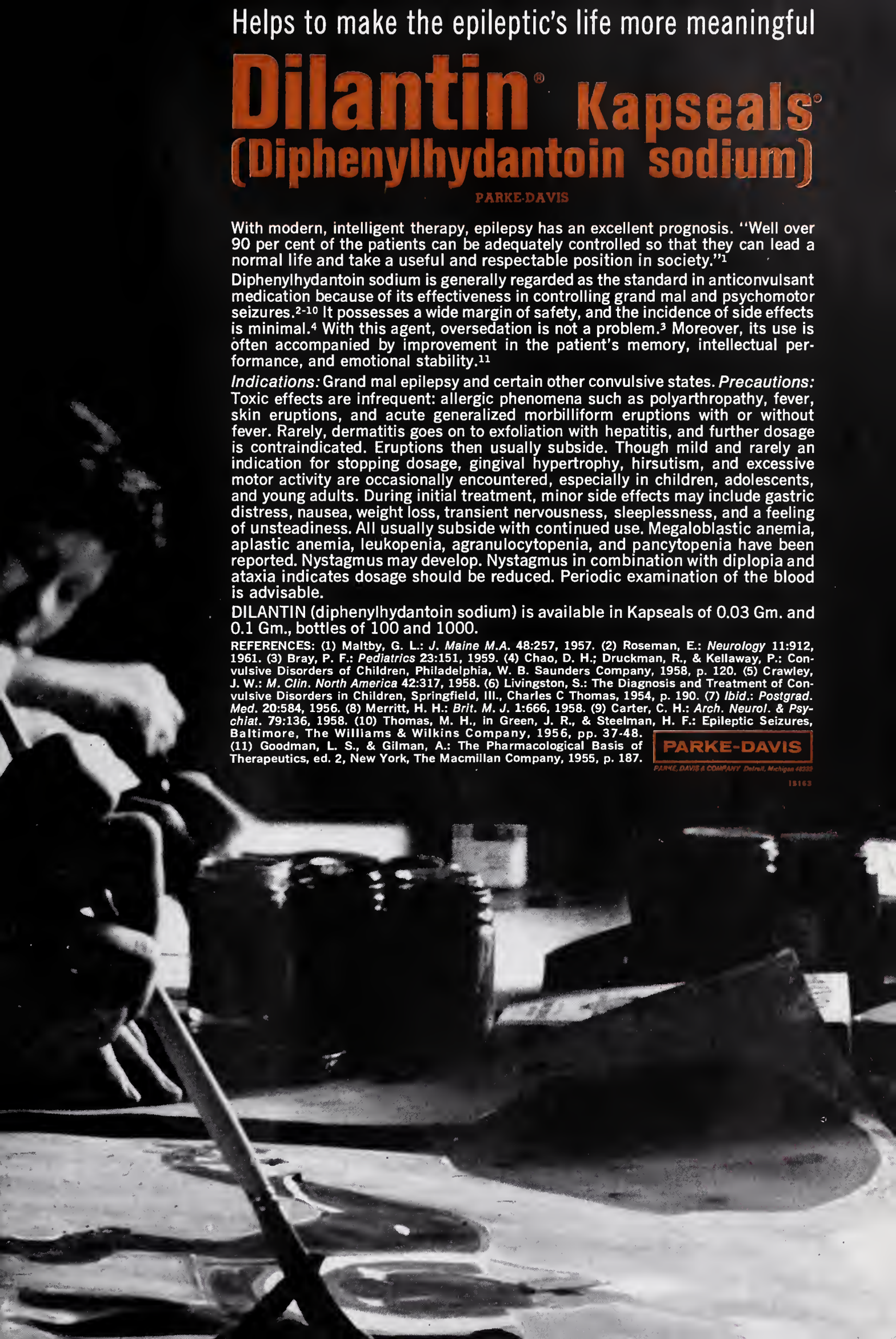
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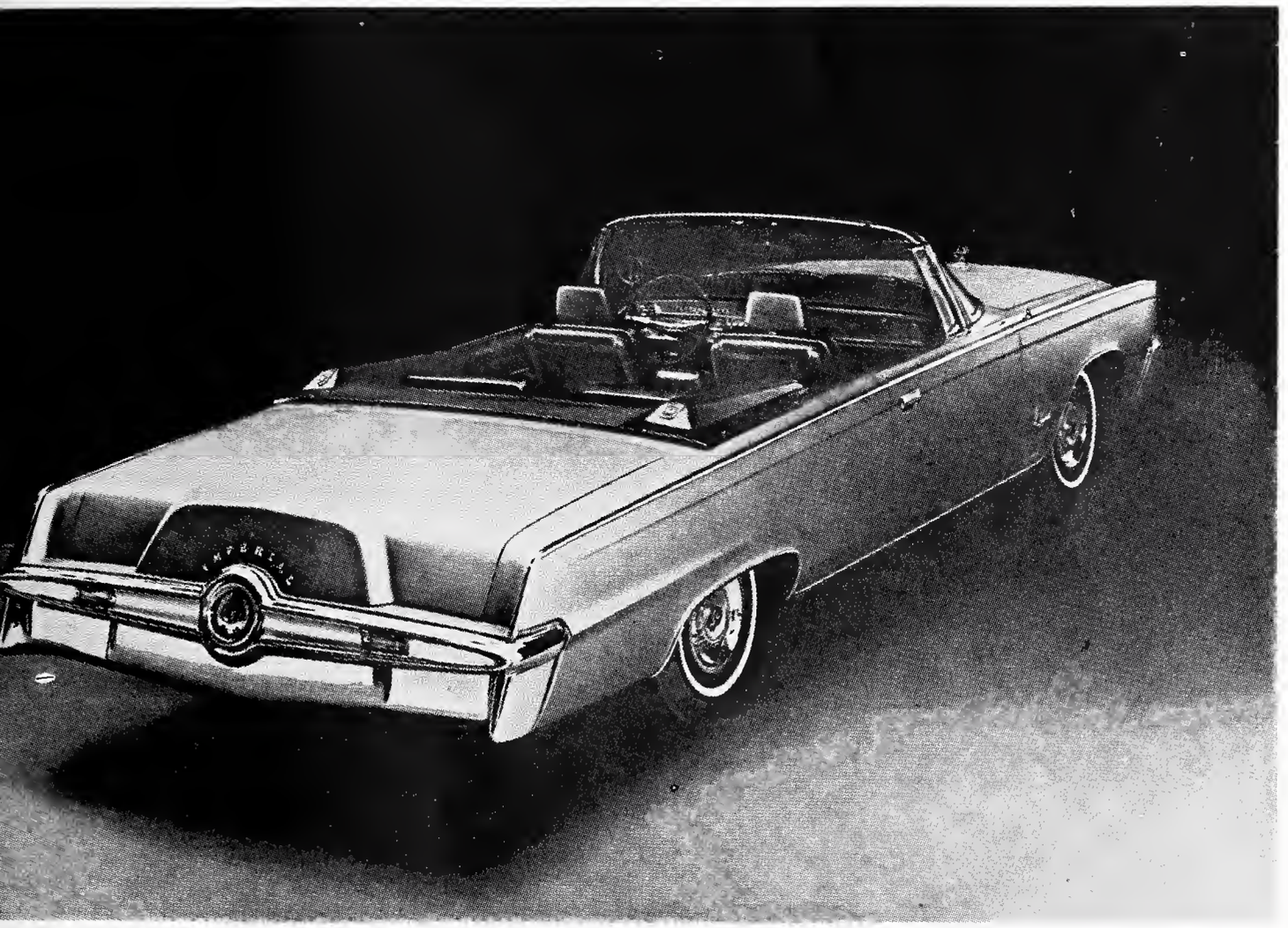
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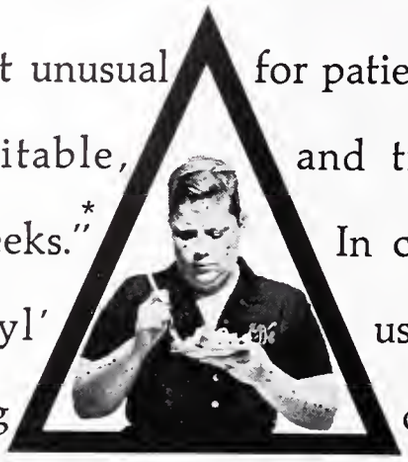
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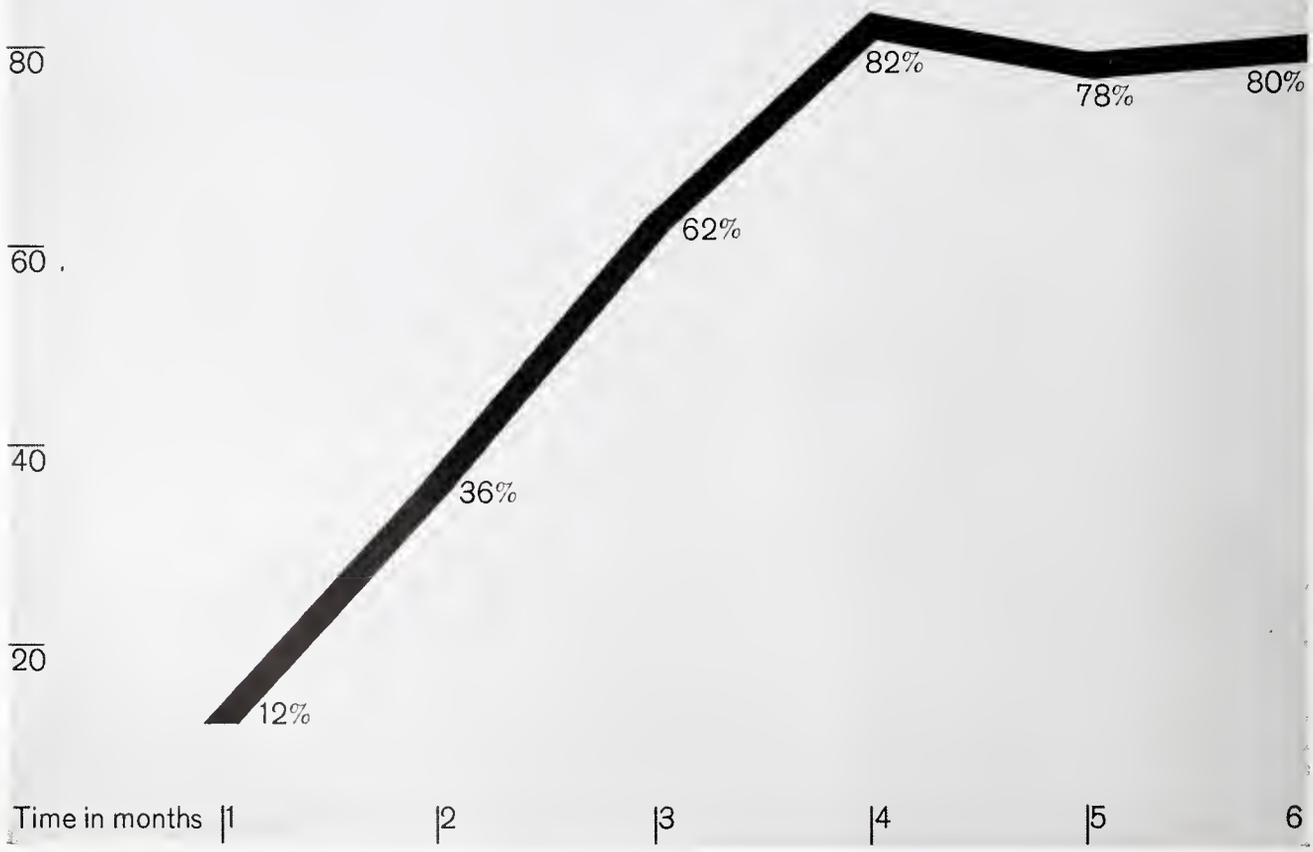
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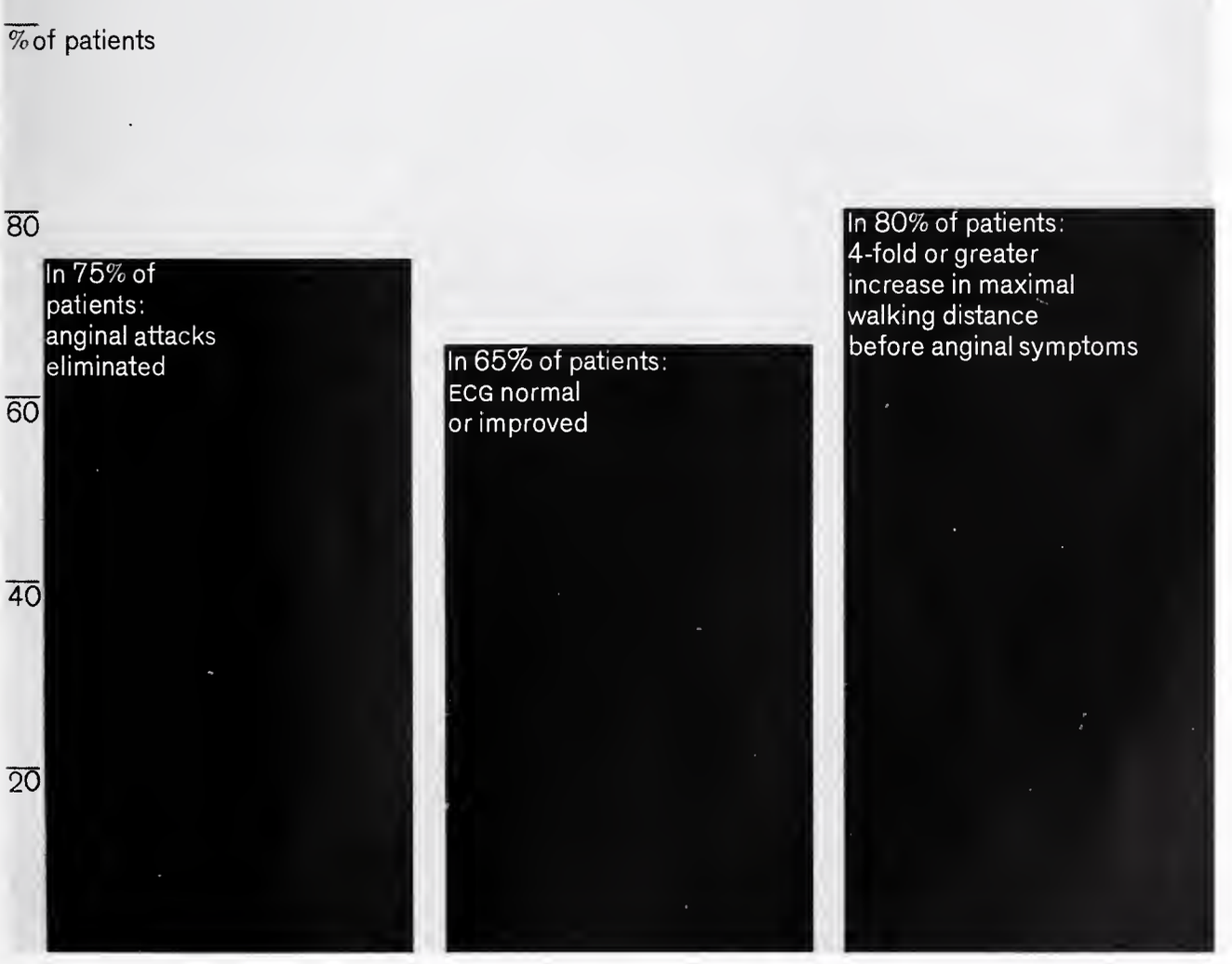
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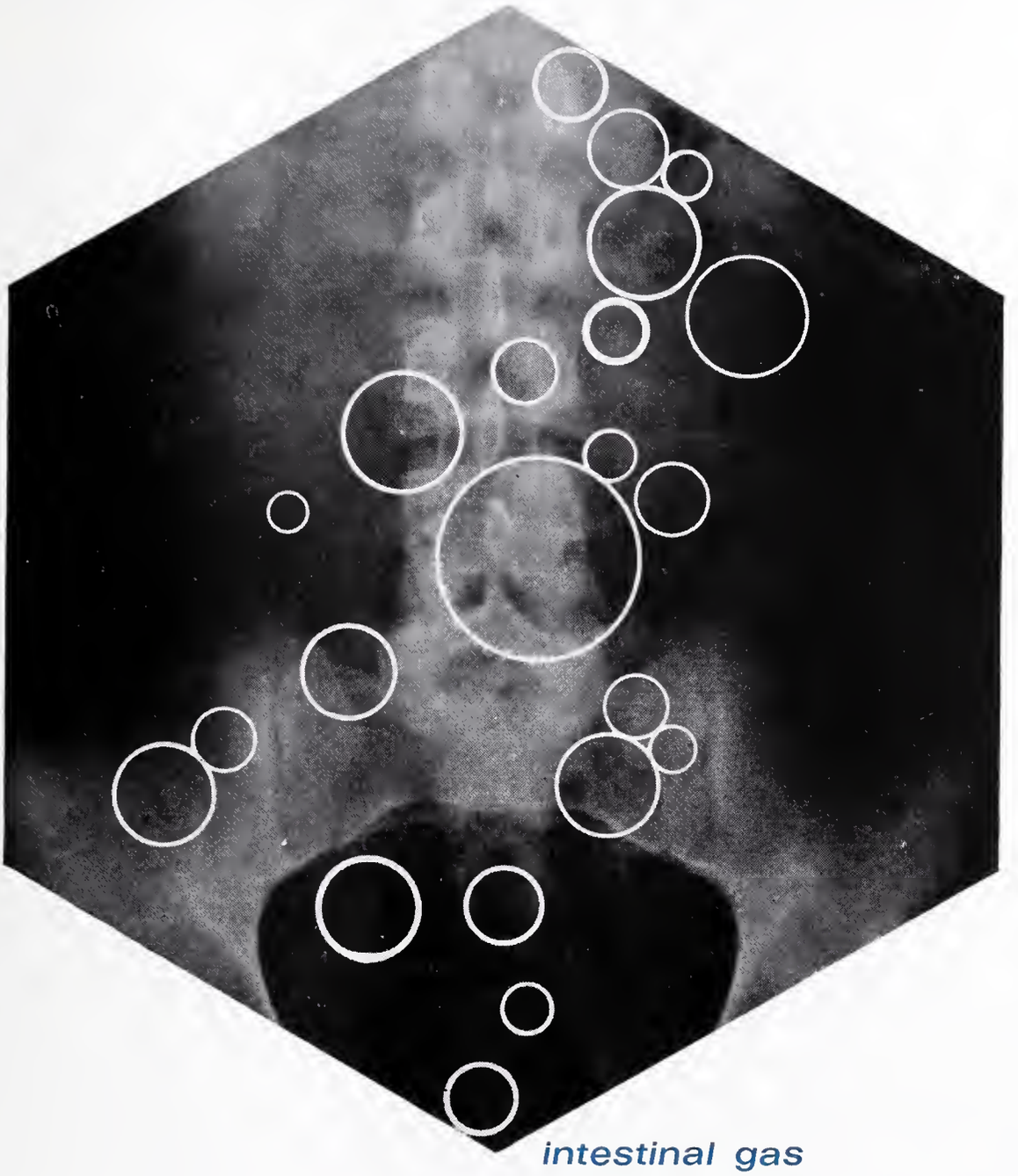
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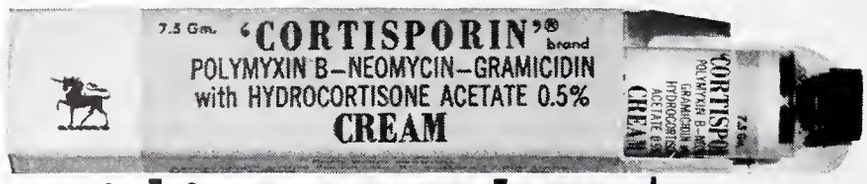
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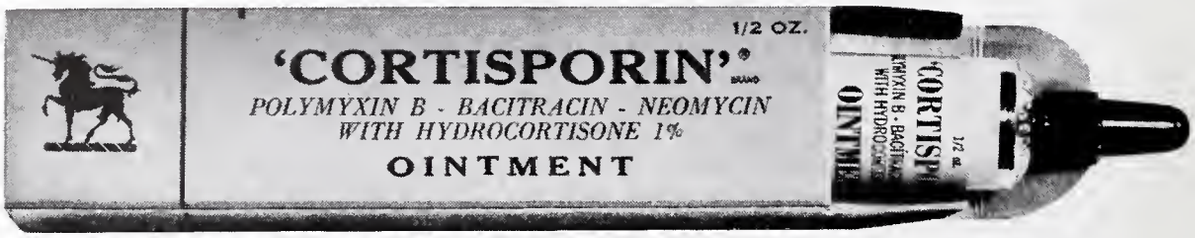
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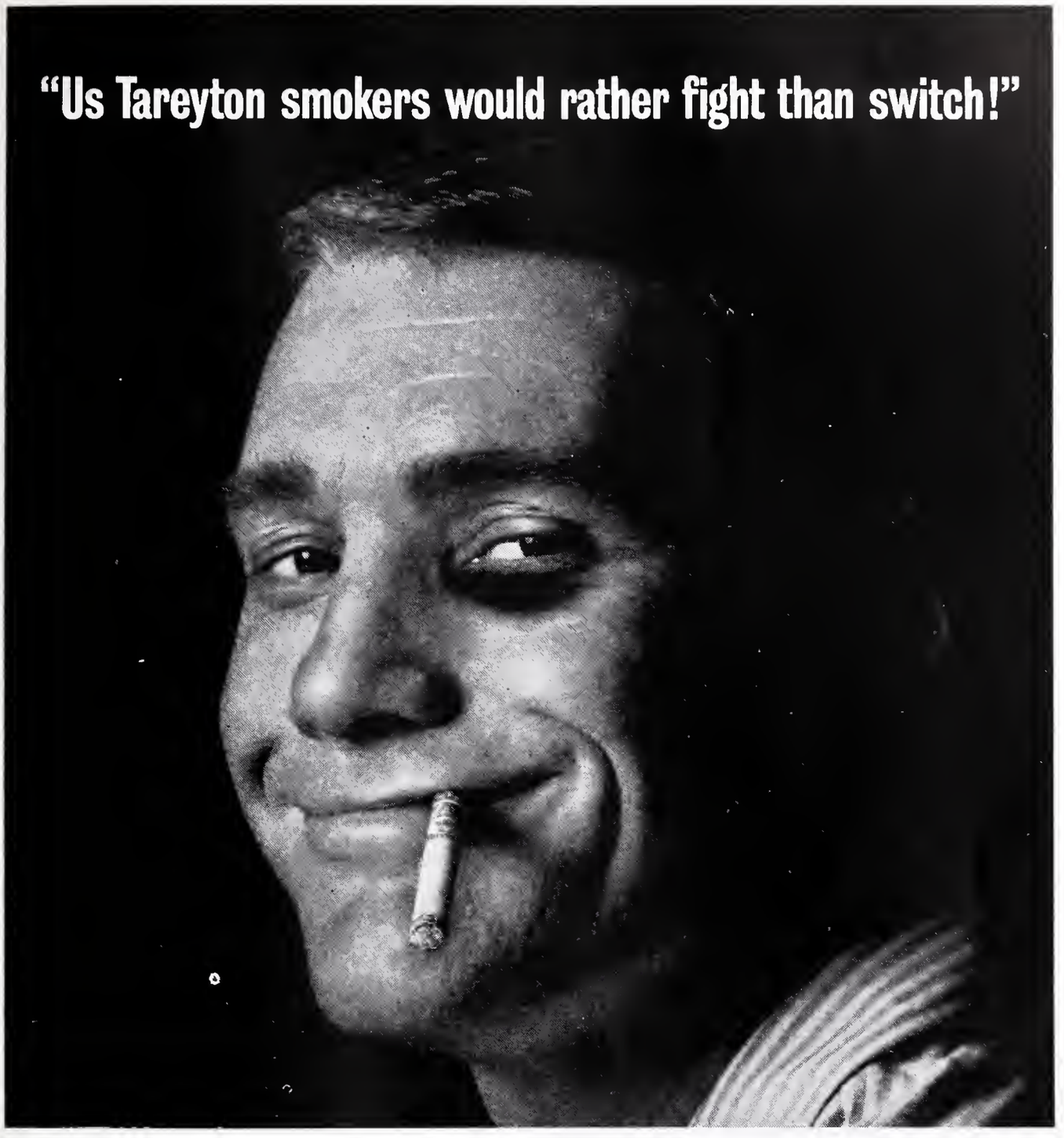
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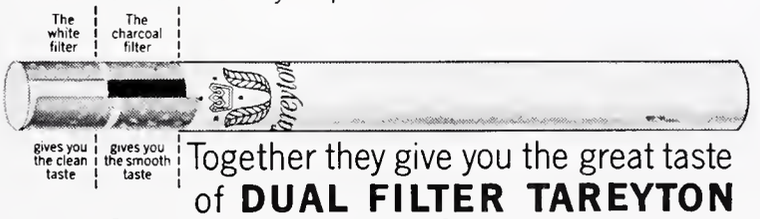
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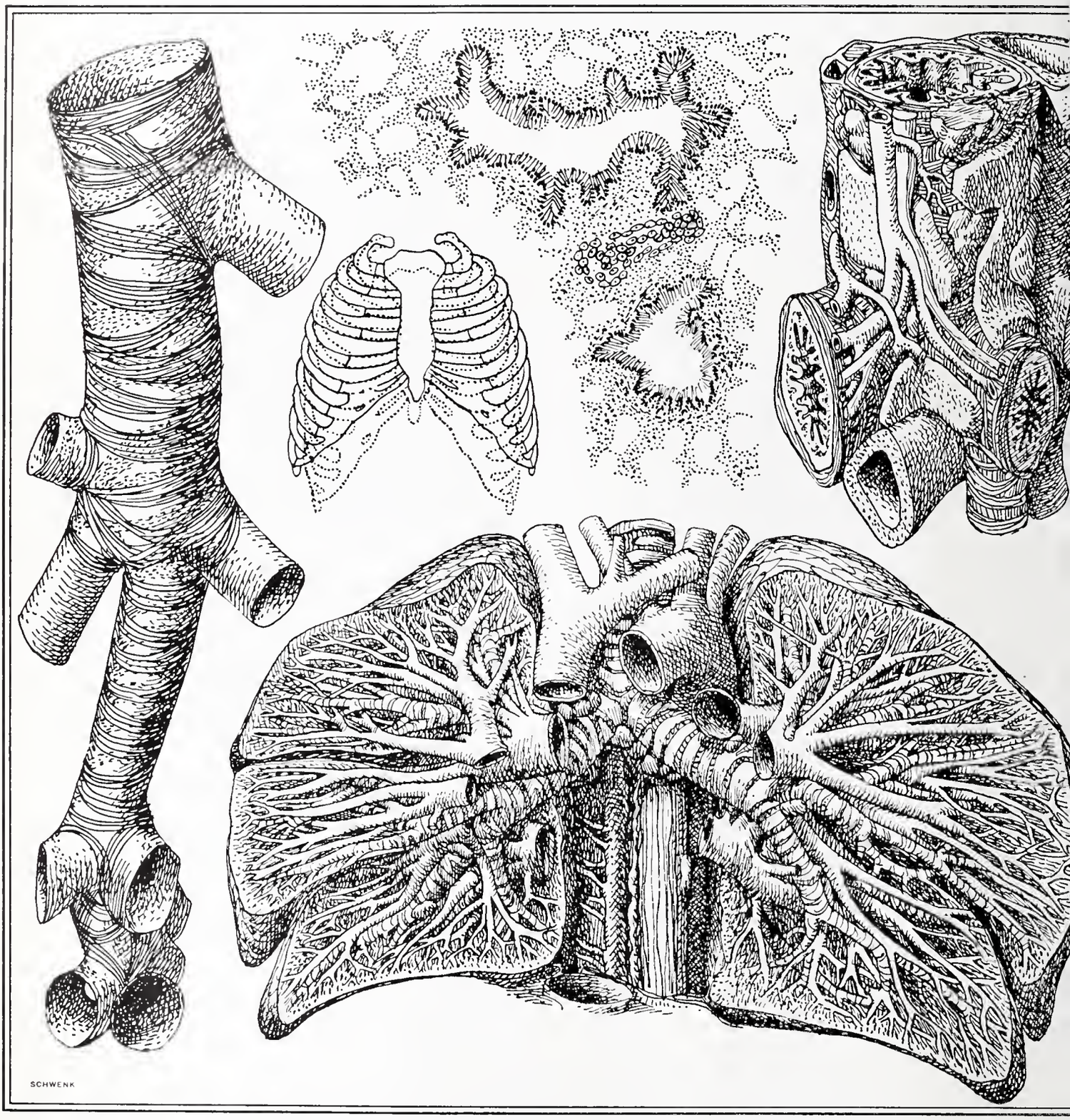
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Don't let comatose patients remain comatose.
Methylphenidate will waken them safely!

Analeptic Treatment of Coma

ROBERT J. HOAGLAND, Col., MC, USA,* *Honolulu*

• *Methylphenidate (Ritalin) intravenously in doses ranging from 20 mg for stuporous patients to 100 mg for comatose ones is a safe and highly effective drug for the restoration of consciousness. One patient required and tolerated 1,260 mg in 45 minutes, without sympathomimetic or other side effects. Its use is suggested in many other situations involving diminished states of consciousness.*

I FIRST treated a comatose patient with methylphenidate shortly before leaving Fort Benning in 1961; the first Tripler Hospital patient was treated in December, 1961. In February, 1963, Captain McCarty (one of our residents) and I reported on the effectiveness of methylphenidate in the treatment of drug-induced coma.[1] Results were so impressive that I decided to continue this form of treatment and also to explore the possibility of applying it to the treatment of coma due to other causes. This paper reports results to date and suggests other uses of methylphenidate.

STATISTICAL DATA

About 130 patients who have ingested drugs to commit suicide are admitted to the Department of Medicine every year. In the period October 1, 1962, through April 30, 1963, 80 such patients were admitted to the medical wards. Patients are referred to as comatose only if they cannot be aroused by command or manual stimulation. The majority of the patients were not in coma.

About two-thirds of patients were women and three-fourths were 20 to 39 years old. These data are consonant with those of civilian hospitals.

Table 1 shows the frequency of admissions.

PHARMACOLOGY OF METHYLPHENIDATE

Methylphenidate,† an analeptic with chiefly cortical and subcortical sites of action, increases psychomotor activity without—unlike caffeine and amphetamine—significant sympathomimetic effects. Animal and human experiments showed that methylphenidate nullified the effect of pentobarbital when given simultaneously, and was antagonistic to the central sedative influences of reserpine and chlorpromazine. Although methylphenidate enhances the effect of norepinephrine, it antagonizes the hypertensive effects of amphetamine. This had practical significance for us, since some of our patients had taken medicines containing amphetamine. Methylphenidate has little effect on the cardiac rate.

It is a relatively safe drug; the intravenous LD 50 dose for rats is 50 mg per kg! Almost all of it is excreted in urine. When human beings have in effect been "pre-treated" with depressant drugs, methylphenidate is infinitely safer than in control subjects.

TECHNIQUE OF TREATMENT

Deeply stuporous patients should be given methylphenidate regardless of degree of stupor or coma when first examined, for many reasons. Let me mention only two: (1) It is impossible to know whether ingested drugs have been completely absorbed or to predict whether the effects of already absorbed drugs will increase or decrease. (2) Many patients ingest more than one drug, and so there may be successive waves of maximal effects.

The goal of treatment: restoration of consciousness. That analeptics used several decades ago had

TABLE 1.—*Monthly admissions for drug ingestion.**

October	1962	19
November	1962	11
December	1962	7
January	1963	14
February	1963	9
March	1963	13
April	1963	7
TOTAL		80
AVERAGE		10.5/month

* Only patients admitted directly to medical wards.

* Chief of Medicine, U. S. Army Tripler General Hospital.
This paper was presented at the 1st USARPAC Medical-Surgical Conference, held at U. S. Army Tripler General Hospital, Honolulu, June 3-5, 1963.
† Ritalin (Ciba).

undesirable effects is irrelevant today. Methylphenidate is a remarkably safe analeptic, which also has desirable vasopressor and respiratory stimulatory effects.

Use of continuous intravenous infusion is required to facilitate intermittent injection, through the tubing. Initially we began treatment of comatose adults with 10 to 50 mg of methylphenidate. On the basis of greater experience I now recommend initial injection of 20 to 100 mg of methylphenidate (depending on degree of stupor or coma). Patients in coma should get initial, and repeated, injections of 100 mg. As long as the patient is comatose or stuporous I recommend giving 20-100 mg every 3 to 10 minutes.

That such intravenous doses are not dangerous (that is, for stuporous or comatose persons) is shown by my having given 1,260 mg in 45 minutes without ill effects to a patient in deep coma. Cardiac rate rose from 80 to 84. Tickton and coworkers gave doses as large as 900 mg in a one-hour period without ill effects.[2] The largest dose we have thus far given is 6,130 mg (within 72 hours). If the patient has required a vasopressor, it may be possible to do without it or reduce the dosage.

In addition to intermittent injection into the intravenous tubing, it may in some cases be expedient to administer methylphenidate by a continuous infusion (flowing into the primary intravenous tubing) in a dose of at least 10 mg per hour. I urge that injections into the tubing be repeated every 3-10 minutes for 36 hours (or longer) if coma persists even if results are not apparent.

Since methylphenidate does not cause degradation or excretion of ingested drugs, the initially effective dose of methylphenidate may be nullified by continued absorption of ingested depressants or by return into circulation of previously absorbed drugs; therefore, watch for return of sleepiness and give repeated doses of methylphenidate whenever consciousness begins to recede. Observations of repeated effectiveness of methylphenidate in the same patient is one of the reasons for my conviction that improvement after use of methylphenidate is not merely fortuitous.

HIGHLY EFFECTIVE

Thus far 25 comatose patients, and dozens who were only stuporous, have been treated with methylphenidate. Our results with comatose patients only are summarized in Table 2.

Coma was considered to have ended when a patient opened his eyes spontaneously or responded to questions or commands. Significant improvement often preceded cessation of coma by many hours. For example, one completely inert patient did not regain consciousness until 14 hours after the first injection of methylphenidate, but 1½ hours after start of treatment she began to swallow, and one hour after swallowing began she made her first spontaneous movement.

TABLE 2.—*Results of treatment.*

DURATION OF COMA AFTER 1ST INJECTION	NO. OF CASES
Under 5 mins.	3
5-30 mins.	8
½-1 hr.	2
1-2 hrs.	2
2-3 hrs.	1
3-6 hrs.	1
Over 6 hrs.	8

The most delayed return of consciousness (with the exception of a patient who sustained extreme brain damage after cardiac arrest) was 44 hours after the first injection of methylphenidate. This patient began to make spontaneous movements, and to cough, 20 hours after the first injection of methylphenidate—that is, 24 hours before regaining consciousness. In this case most of the methylphenidate was administered slowly (placed in the flask containing fluid for continuous intravenous infusion). I believe that intermittent injection into the tubing would have given faster results in this and several other cases.

Our experience has shown that methylphenidate can antagonize effects of extremely large amounts of barbiturates, ethyl and other aleohol, ethinamate (Valmid), meprobamate, phenothiazines, Librium, Doriden, Darvon, Benadryl, Zactyrin, Nytol, Sominex and other hypnotic, sedative, analgesic, or otherwise depressant drugs. We cannot prove that any of our patients would have died without methylphenidate, but I believe at least two would have died. In any case, merely curtailing coma has many advantages. These advantages should be obvious, but they seem to be overlooked by physicians who are wedded to the opinion that patients who have ingested depressant drugs are not saved by analeptics, and so do not use them.

Return of consciousness allows patients to swallow liquids and medications (thus facilitating nursing), and to cough up sputum and hawk mucus (thus reducing the danger of aspiration pneumonia and the number of tracheostomies performed). Return of consciousness reduces the number of attendants needed, allays the worry of the family and of physicians, allows interrogation by physicians and others. It obviates the need for urinary catheters. Finally, ward officers can spend more time with other patients if consciousness is restored faster.

HAZARDS SLIGHT

Are there any dangers in using methylphenidate? We gave four patients over 1,000 mg of methylphenidate without any undesirable effects,

except that one patient vomited. Unlike amphetamine and caffeine, methylphenidate, even in huge doses, did not produce arrhythmia. Indeed, arrhythmia of one patient ceased a few minutes after the first dose of methylphenidate was given.

DOSE RANGE BROAD

Evaluation of any treatment of drug-induced coma is hindered by many uncertainties about what and how much was ingested and just when. Many patients are drunk or confused when they ingest drugs; others exaggerate the number of tablets taken, or depreciate, or simply do not remember. The exact amount of alcohol consumed is never known. How much of the ingested drug will be absorbed after the onset of treatment is never known. Despite these and other imponderables, change from coma to consciousness within a few minutes in several cases, and within 30 minutes in 44 per cent of cases, permits the inference that methylphenidate accelerated return of consciousness. Several patients did not regain consciousness for periods of 12 to 44 hours. At first I thought these cases represented failures of analeptic treatment, but I have changed my mind.

One woman who, I believe, would have died if methylphenidate had not been given, received the first dose about 11 hours after ingesting sodium amytal. This patient, who regained consciousness after 44 hours, had an initial blood barbital level of 17.1 mcg/ml of blood calculated as Seconal (high enough to have been fatal). Return of reflexes, swallowing and spontaneous movements preceded return of consciousness by 24 hours. She received 3,860 mg of methylphenidate.

LOWERED FATALITY RATE

Another support for my belief that this treatment of coma has influenced the outcome favorably is our fatality rate. Hospitals with a suicide admission rate as high as ours (estimated at 130 annually) may be expected to have *at least* one to three deaths annually. No patients who attempted suicide by drug ingestion have died since use of methylphenidate began one and one-half years ago, whereas there were two deaths due to drug ingestion in the preceding ten months.

MANY OTHER USES

Next, let me state briefly a few other uses for methylphenidate. We have given methylphenidate, with dramatic results, to one patient who was stuporous and psychotic because of water intoxication. Five mg of methylphenidate intravenously restored mental clarity. Her basic disorder was then successfully treated. The fact that her mental state relapsed partially and immediately responded to another small dose of methylphenidate indicated that restoration of mental acuity was indeed brought about by methylphenidate.

We have been using methylphenidate successfully in another way. Patients who have had acute upper gastro-intestinal bleeding are examined promptly by esophago-gastroscopy. This procedure is often preceded by administration of Seconal, Demerol, and Phenergan. As a result, these patients must be watched by an extra attendant en route to the radiology department and may be too somnolent to cooperate well at the roentgenology department. Captain McCarty and other residents have been giving these patients 5-20 mg of methylphenidate intravenously after endoscopy with almost immediate return of mental acuity.

Perhaps coma produced by systemic infections and by head trauma may be remediable by methylphenidate.

Intravenous methylphenidate should be useful in treating stuporous newborn babies and in getting them to breathe.

Patients are often brought to the emergency room suffering from injuries and also from the effects of ingested alcohol. Giving methylphenidate may help answer the important question—how much of the patient's stuporous state is due to alcohol and how much is due to trauma? In war time, field hospitals received wounded who had been given morphine on the battlefield and were stuporous. If we had had methylphenidate then, we would have used it to restore mental acuity of these patients.

SUMMARY

1. Intravenous administration of methylphenidate (Ritalin), a relatively new analeptic, accelerated return to consciousness of comatose patients who had taken depressant drugs to commit suicide.

2. Methylphenidate intravenously, in doses over 6 gm, produced no undesirable effects.

3. The advantages of accelerating return of consciousness warrant the use of a safe analeptic even if the mortality rate is not affected.

4. Methylphenidate has been useful in abolishing stupor unrelated to drug injections; additional exploration of such use will be conducted. ■

U.S. Army Tripler General Hospital

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The risk of a disabling injury is 13,666 times higher in high school football play than in underground coal mining.

High School Football:

Valuable Sport or Sado-Masochistic Excess?

FRANK L. TABRAH, M.D., *Kohala*

• *High school football injuries of disabling severity sustained during 7,530 man hours of practice and 140 man hours of play at two Big Island schools in 1962 totaled 92—69 of them during actual play—and resulted in 111 days of lost time. The frequency of such injuries in football game play is nearly 14,000 times higher than in the most hazardous American industry: underground coal mining. Their severity in football is only slightly lower than in that hazardous industry, and much greater than in either lumbering or marine transportation, which are far safer. The near-hysterical disregard of risk that characterizes football play appears to be a major factor in this. It would seem highly desirable to shift emphasis from football to a sport that players might continue to enjoy after high school and college.*

DESPITE the fair body of literature available on teenage athletics,[1-5] little statistical information has been published on high school football injuries. Previous medical articles have discussed the risks of playing high school football in comparison with the alleged educational and character-building benefits to the teenage player.

Because we were struck with the seemingly high incidence of football injuries in two schools, one private and one public, for which we have kept injury records for several years, we have extracted figures from our files covering the football season of 1962-1963, for comparison with injury rates in several high-risk occupations such as underground coal mining, logging, and construction work, to realistically evaluate the hazards of disabling injuries in football.

The year 1962 is in no way unique—the incidence and severity of injuries in 1962-1963 is about our usual experience over the years. Nearly all injuries were treated at one of two dispensaries, or at the hospital with which we are associated. Injuries treated elsewhere have been recorded whenever possible, so it is unlikely that more than one or two injuries have thus escaped this study.

Injuries were sustained in one of two categories, one-fourth during practice and three-fourths during interscholastic play. The total man hours of practice differed considerably between schools; one school spent 2,740 hours, the other 4,930 man hours in practice and play. Both schools totaled 70.4 man hours of actual play.

TYPES OF INJURIES

The nature of the 92 separate injuries sustained in the 1962 season by the combined teams is as follows:

Sprains:
- knee—16
- ankle—10
- shoulder—5
- elbow—4
- other—25

Fractures: (all confirmed by x-ray)
- knee—1
- ankle—2
- clavicle—1
- humerus—1
- radius—1
- wrist—1
- vertebra—1

Dislocations:
- elbow—1
- clavicle—1

Concussion, moderate—3
Spike perforation—10 (50% infected)
Contusions severe—5
Abdominal trauma, moderate to severe—2
Hematoma—1
Laceration—1

TABLE 1.—*Total man hours at each school; number of injuries and when suffered; and lost time.*

	TEAM I	TEAM II	TOTAL
Number of members	33	36	69
Total man hours exposure to injury in practice and play	2740	4930	7670
Total man hours exposure to injury in play only	70.4	70.4	140.8
Number of injuries	60	32	92
Injuries during play	45	24	69
Days, "Lost time" in hospital, dispensary, infirmary, or quarters	59	52	111

Many minor injuries occurred that were never reported to medical personnel by students until after they were healed, for fear they would be excluded from play.

Table 1 indicates total numbers of injuries by teams and when they were sustained, and provides totals from which Table 2 is derived. An occasional player had two or more distinctly separate injuries; these were counted separately. Any error introduced is probably balanced by unreported injuries.

Table 2 contains figures computed from Table 1 as follows, according to the American Standard Method of Recording and Measuring Work Injury Experience, Code Z 16.1—1954, pg. 10:

$$\text{Disabling Injury Frequency Rate for teams combined} = \frac{\text{no. of injuries} \times 1 \times 10^6}{\text{Total man hours exposure}}$$

$$\text{Disabling Injury Severity Rate} = \text{"Lost time"} = \frac{\text{no. of days spent as in-patient or on trips to hospital, dispensary, or infirmary} \times 1 \times 10^2}{\text{Total man hours exposure for teams combined}}$$

In comparing disabling injury severity rates with industrial figures, it appeared unrealistic to calculate "lost time" as full days, since many injured players could continue to attend classes with casts and crutches; however, an estimate of lost time includes many half-days spent in securing treatment, repeat X-rays, cast changes, etc. Hence, the disabling injury severity rate is corrected to:

$$\frac{\text{one-half lost time days} \times 1 \times 10^6}{\text{total man hours exposure}}$$

It will be noted that the disabling injury experience during football practice and play, and play only, is several hundred times higher than the published rates for several hazardous industries—in fact, 13,666 times higher for play alone, compared with the highest reported industrial rate of injury, that of underground coal mining.

It will be noted also that the disabling severity rate is similar to the coal mining rate, and several times higher than the lumbering or marine transport rate, and over ten times the rate for all industries.

Table 3 outlines some of the weight-injury relationships of the two teams. Although three out of four of the most severely injured players had weights below the means for their teams, mean weights of the players sustaining multiple or severe injuries are surprisingly close to the mean weights of the teams as a whole, indicating that the risk of injury is fairly evenly shared by all team members, regardless of their weights.

FOOTBALL HYSTERIA

It is not the intent of this brief report to analyze the causative factors in these surprisingly high rates of trauma. However, powerful psychological factors are at play along with the players.[6] Most boys will doggedly continue play after sustaining injuries that should absolutely disqualify them. It is our observation that the prudence students customarily exhibit in other sport activities is noticeably absent from football. It appears from

TABLE 2.—*Comparison of frequency of occurrence, and severity as measured by lost time, of injuries in football play and in three of the most hazardous American industries; per million man-hours' exposure.*

Disabling Injury Frequency Rates

All industries	5.99
Marine Transportation	20.85
Lumbering	22.13
Underground Coal Mining	35.86
Football, Practice and Play	11,995
Football, Game Play alone	490,060

Disabling Injury Severity Rates

All industries	666
Lumbering	1,921
Marine Transportation	3,848
Football, Practice and Play	7,177
Underground Coal Mining	10,816

TABLE 3.—*Lack of any apparent relationship between players' weights and the frequency or severity of injuries incurred.*

Range of Weights in lbs. of players:	TEAM I	TEAM II
Maximum	203	220
Mean	153	149
Minimum	118	117
Numbers of Players at extremes of weights	1>200 1<125	3>200 3<125
Mean weights of players sustaining injuries requiring hospitalization, and multiple (2 or more) injuries	153	149
Weights of Players with season's two most severe injuries* in each team	140 118	129 155

* Severe abdominal trauma; fracture, humerus; fracture, knee; fracture, vertebra.

talking with students that what is sometimes called "football hysteria" arises from parental pressures, intragroup tensions, a warped concept of what it means to be "tough," and in some cases, the hope of securing a college football scholarship.

Along with these emotional sets, which seem to strip most players of rationality, the over-all drive to "win at any cost" is interesting. It is this, we feel, that leads to the greatest excesses in play, and the most severe injuries, despite elaborate protective devices.

Although it is said by football proponents that football scrimmage is an outlet for hostility, our observation is that much more hostility between teams, communities, and racial groups is generated out of football games than would otherwise exist.

High school football has other features which merit discussion. Football will always remain essentially a spectator sport. Relatively few students are varsity football material. Astonishing amounts of time and effort are expended on a sport skill that virtually no one utilizes after high school or college age.

It is remarkable that over the years we have developed the complex program we now have for insuring football training and play, when football is about the only sport no one but the professional engages in after his school days.

SUBSTITUTE SPORTS

Considering the general physical state of our obese, underexercised population, it would seem wise to relegate football to a minor place in sports programs generally, replacing it with sports training that can be utilized by everyone until he is "too old to crawl." Tennis, scuba diving, swimming, wrestling (judo and karate), and for those who wish to really learn to be "tough," a well-planned course in hand-to-hand combat, such as is used in Marine training—such activities would give a much better basis for lifetime physical fitness than our present football programs provide, with far less risk of severe, often permanent injury[7] and loss of useful time.

If the injury and severity rates we have found associated with football were justified by the continued activity in the sport after schooling is over, it would, despite the risks, be a valuable activity.

In the absence of such usefulness, other sports might well be stressed. Re-education of parents, communities, and students would be slow. Football thrives on glorification by the mass media such as TV, movies, and the sports page. Football, an extremely high-risk spectacle with little long-term benefit to most players, is today's equivalent of the gladiator contest.

As new recreational and sports facilities develop, football should ultimately assume its proper perspective. ■

Kapaau, Kohala, Hawaii

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The unfamiliar and hostile environment of outer space poses new and challenging problems for "space doctors."

The Man in the Loop

ROBERT H. MOSER, Lt. Col., MC, USA, *Honolulu*

• *Many problems beset the physician concerned with maintenance of man's health in the hostile environment of space. Weightlessness, oxygen supply, cosmic radiation, food supply, waste disposal, alleviation of boredom and fatigue, temperature control, extremes of acceleration—all these and more require careful attention, and many have not yet been solved.*

THE INTEGRATION of man into the space vehicle or placing the "man in the loop" represents an experiment of limitless imagination and technological skill. In the early days, when interplanetary exploration was in the idea stage, with bright young space engineers exchanging practical dreams around large tables, there was a significant segment of this elite corps which was not convinced that man had a place in the early exploration of outer space.

Engineers are a practical group. They deal in a world of mathematical accuracy where performance is predictable, error is reprehensible and indecision unknown. Many felt that with their little black boxes they could obtain data concerning the mysteries of outer space that would be reliable and informative, without the necessity of integrating human frailty into the mathematical equation. There is much to be said for this philosophy. To date we have launched over 70 successful unmanned space vehicles; the remarkable success of the Tiros weather satellites, the Pioneer V 22.5-million-mile deep-space probe, the Telstar communications satellite, and multiple others, attest to this.

The average astronaut weighs 165 pounds, occupies approximately six cubic feet, and has a built-in potential for error. The engineer was not sure that he could not duplicate virtually everything that man could do, with black boxes of less weight. In addition, the integration of man into the capsule introduced many other problems. Man is a most delicate creature. To protect him during launch and re-entry and support his viability in the hostile environment of outer space presented an enormous task.

Finally, the discussion was resolved and the engineers were convinced that, despite the extra weight and mass of man, he was perhaps worth the effort—because man had a brain. Even the cleverest engineers could not devise a computer that could *think* with elasticity and initiate action, and still put it into as small a package as the human brain. Despite several tons of sophisticated, unemotional hardware whirling about this sphere —each firing its lovely orderly data to busy earth-bound computers—only John Glenn saw the fireflies. If this sounds somewhat facetious, I can assure you that, until the successful flights of Shepard, Grissom, and Glenn, there were many of us who were concerned as to whether man had been introduced into the space craft somewhat prematurely.

GRAVITATION PROBLEMS

How far we have come in the integration of the "man into the loop" is revealed by a brief look at the orientation of the Mercury program. Our sole purposes are to prove and improve man's capability to survive the vicissitudes of *launch, survival in outer space,* and *re-entry,* and to study his ability to be usefully integrated into the vehicle operation. Prior to the moment when Alan Shepard was sealed into Freedom 7 atop a Redstone ballistic missile, seven highly trained, supremely motivated, and physically superior young men were subjected to every type of stress that could be anticipated during an orbital space voyage with the exception of the prolonged weightless state.

From knowledge gained in ballistic flights of Atlas missiles, it was ascertained that the maximum G load to which astronauts would be subjected during nominal flight would be in the range of 7 G's. In the event of an abort situation in which the astronaut was hurled from the top of

(The opinions expressed in this article are solely those of the author and do not reflect the policies or attitudes of the National Aeronautics and Space Administration.)

* Assistant Chief of Medicine, Tripler General U. S. Army Hospital. Aero-Medical Flight Controller for Project Mercury.

Received for publication June 24, 1963.

an ailing Atlas booster by firing of the escape rocket, a maximum load of 15 to 30 G's for one second was anticipated. It was also estimated that in the event of a land impact the astronaut could be subjected to a force of approximately 80 gravities. This prompted investigations on the rocket sled at Holloman Air Force Base in which anesthetized animals were subjected to 38 times the force of gravity for short impulses. Colonel John P. Stapp has taken transverse decelerations of 40 G's for 0.5 seconds without injury. This was considered the upper limit of human tolerance.

It was estimated that a human subject within a capsule in the restrained, aft-facing, semi-supine transverse orientation could survive the 80-G impact on land if the spacecraft were provided with attenuation devices that would lower the load from 80 to below the 40-G test data. This is done in Mercury by crush honeycomb below the couch. In addition, the acceleration on landing was further softened through the use of a pneumatic landing bag. In the final configuration, the crush material acts as emergency backup to the landing bag. This combination keeps landing loads to 15 G or less and is easily accepted by the astronaut.

ACCELERATION TRAINING

In addition, the astronauts themselves were trained on the "human centrifuge" at Johnsville, Pennsylvania. On this incredible device they were all accelerated up to 14 G's positive transverse gravity ("eyeballs in") for brief periods of time. Most of them were able to tolerate this quite well, with actual improvement in performance with repeated exposure and the learning associated with it. In addition, several were subjected to a 9-G turnover, which means that they were revved up to 9 G's positive transverse acceleration ("eyeballs in") and then suddenly flipped 180° to 9 G's negative acceleration ("eyeballs out"). This also was tolerated. With these provisions and training, the astronauts were well prepared for the normal and emergency G-loading forces to which they would be subjected in launch, re-entry, and landing on the Atlas mission.

Noise and vibration were considered potential sources of hazard. Tapes were recorded at various distances and positions from an Atlas engine during static firing. These were played to the astronauts during periods when they were solving cockpit problems while lying in a mock-up of the Mercury capsule. The loudest sound levels associated with an Atlas-borne capsule have been 165 decibels. However, this is well attenuated before reaching the pilot's ear drums by structure, insulation, suspensions of the couch and helmet liners.

The only vibration difficulty encountered in actual flight was in the early launch phases of the Redstone mission when the missiles were approaching "max Q" where the forces of velocity and the resistance of gravity and atmospheric density grapple, to produce maximum stress on missile, space craft, and man. Astronaut Shepard observed some vibration. The couch support was modified and the problem corrected by the time of Astronaut Grissom's flight. It has not been a problem on Atlas missions.

PROBLEMS OF RESPIRATION

A major consideration in design was the life support system. This was the first time a major closed environmental system had been built in the United States. For a considerable time prior to launch, the suit and cabin environment are flushed with 100% oxygen. The astronaut breathes pure oxygen and thus eliminates about 97 per cent of the nitrogen from his body. All other gases during the purge are vented over the side. When the cabin-and-suit system reaches near 100% oxygen, the space craft system is switched on. Thereafter, the astronaut flies in a 100% oxygen environment, but the pressure is allowed to reduce from 14.7 to about 5.1 pounds per square inch (psi). This is equivalent to 27,000 feet altitude, or 259 mm of mercury.

Throughout the flight, 100% oxygen is delivered to the astronaut on demand from one of two bottles containing oxygen stored under high pressure. The oxygen pressure is redueed by passage through a series of valves before delivery of it to the suit inlet. I won't go into the details of the many safety features built into this system. Suffice it to say that the suit with face-plate closed, and the cabin, have completely autonomous environmental control systems. This is important reduplication. In the rare event of cabin perforation by a meteorite or an electrical fire requiring the cabin atmosphere to be dumped overboard, the astronaut may close the face-plate and live in the environment of the suit in safety and comfort, long enough to permit correction of the problem or to return safely to earth.

Carbon dioxide control has not presented a significant problem. This gas is absorbed by a lithium hydroxide system which takes up carbon dioxide as it is produced by the astronaut. Detection of rising pCO_2 has presented a problem. The development of a space flight instrument that is sufficiently sensitive to detect the rather infinitesimal amounts of CO_2 that may make the difference between tolerable limits and hypercapnic toxicity, and is reliable when exposed to the rigors of space flight, has been diffieult. For example, nominal pCO_2 at the suit inlet is around .02 psi or 1.0 mm

of mercury. Earliest toxic signs and symptoms begin at .05 psi or 2.6 mm of mercury and reach distinctly toxic levels at 10 mm of mercury. By comparison, with oxygen we are dealing with ranges of 5.1 psi or 259 mm of mercury, optimally; danger areas begin at 3.8 psi or 197 mm of mercury. It is believed that a CO_2 detection device now being tested will be satisfactory, and may be incorporated into the MA-9 space craft. In any event, we have been flying without a pCO_2 instrument monitor and have had to rely upon increases in depth and rate of respiration, and on pilot comfort and orientation as our end points. This is admittedly a less than optimal situation, but thus far we have had no difficulty.

The pressure within the cabin, as I have stated, is maintained at 259 mm of mercury. Since oxygen is the only gas in the system, cabin pressure is equal to O_2 partial pressure, greatly simplifying matters.

HEAT PROBLEMS

Heat was considered a major environmental hazard in early planning. The engineers assured us the problem was solved, and indeed it is. Once the retro rockets have been fired and the spacecraft has been slowed to suborbital velocity, it begins its searing descent through the ever thickening atmosphere. From 55 miles altitude to 12 miles, which represents a slant distance of about 760 miles, the space craft will decelerate from 17,500 miles an hour to about 270 miles an hour. This occurs in a terribly long five minutes. It is during this period that the maximum heat buildup takes place. With the space craft oriented at −1.5°, the heat shield is deployed to accept the friction; there is a maximum heat pulse of up to 3,000° F. at the apex of the ablation shield for about two minutes. This heat deflector consists of a tough fiberglass resin, which boils away during re-entry. The ablating of the material reduces the temperature transmitted to the rest of the space craft considerably. The outer wall of the shingled cabin peaks up to 1,000° in the area of the cockpit. Although the early estimates indicated that the inner cabin wall might rise to about 170°, it has been in the range of 90 to 106° during the orbital missions to date. The temperature within the suit, with face-plate closed, has been held between 66° and 86° during these heat pulses on the cabin, and the rectal temperature of the astronaut has not changed at all. We think this is pretty good refrigeration.

I don't want to go into all the details of environmental and life-support systems on re-entry. Suffice it to say, they have all worked with great effectiveness. The astronaut is exposed to the atmosphere of earth at approximately 17,000 feet through the automatic opening of snorkel valves. Temperatures on the water have actually been a greater problem than those encountered during re-entry. This is primarily due to the high temperature and humidity in the waters off the Florida coast. If ambient temperature exceeds 97° or humidity 58 per cent, the astronaut must leave the capsule.

VARIED FUTURE PROBLEMS

Looking to the future, we will have many new and different problems. It is evident that man living in the closed ecologic system of the space craft for periods of weeks to months presents a new constellation of problems. In all probability man will have to fly in an atmospheric environment carefully validated to insure that it is the equivalent of the natural state on earth.

For example, there is some reason to believe that breathing 100% oxygen for prolonged periods of time, even at reduced pressure, may be deleterious. Better sensing devices for CO_2 buildup will be needed and a new system for CO_2 removal will be necessary. Significant work has been going on for years in the area of the "flying farm," where a closed and balanced system utilizing algae such as Chlorella in the production of oxygen and the utilization of CO_2 has been studied.

Storage and preservation of food and disposal or utilization of waste are problems which must be resolved.

Other areas for resolution are cosmic radiation, ecplexia (the psychologic phenomenon of breakoff as one watches the earth disappear in the darkness of space), the problems of boredom, isolation, and fatigue, and not least the mystery of prolonged weightlessness. The latter has not been a problem in any of the Mercury missions, nor apparently in any of the Soviet orbital flights. However, one cannot expect that the human organism, which for thousands of years of painful evolution had adapted its homeostatic mechanisms to the upright posture at 1 G, will not experience some physiologic disruption when deprived of this attitude for prolonged periods of time. There have been some ingenious suggestions for creating artificial gravitational sensations which may keep our proprioceptors happy.

THE SKY'S NOT THE LIMIT

We are in reach of the moon and beyond. Man has been incorporated as an active participant in this exciting adventure. The disciplines of medicine and astronautics have been married in this greatest of scientific ventures. Our horizons are literally unlimited. ■

U. S. Army Tripler General Hospital.

When is a "black eye" not just a black eye?

When it's a fracture of the orbital floor!

Fractures of the Orbital Floor

HERBERT G. PANG, M.D., L. Q. PANG, M.D., and
RICHARD D. MOORE, M.D., *Honolulu*

• *A cursory examination that terminates in a presumptive diagnosis of a simple black eye is hazardous, because if a fracture of the orbital floor is not immediately repaired, muscles incarcerated therein become fibrotic. Late repair will result in persistent diplopia. Early and efficient diagnostic workup is of the utmost urgency. We emphatically underscore the necessity of serial laminagrams in all suspicious cases. Ordinary x-rays not infrequently fail to demonstrate fractures of the orbital floor.*

A CASUAL approach to the obvious evidence of a blackened eye may lead the physician to the false hope that subsequent reduction in swelling and ecchymosis will be accompanied by a return to normal appearance and function. However, such is not always the case. What may appear to be a simple phenomenon—a black eye—may upon careful examination reveal a fracture of the floor of the orbit. Suspicion of such a fracture should be entertained when the following signs and symptoms are present:

1. Ecchymosis and edema of the eyelids.
2. Diplopia, sometimes from the beginning.
3. Pain on altering direction of gaze is a constant finding.
4. Limitation of elevation of gaze.

TESTS

The following tests should be made:

1. *Traction test.* Local anesthetic is instilled into the conjunctival sac. The globe is elevated with forceps placed in the six o'clock position. In most cases, if an orbital fracture with muscle incarceration is present, the globe will resist elevation beyond the horizontal meridian.

2. *X-rays.* A diagnosis of blow-out fracture of the orbit by x-rays is frequently missed if the x-ray examination is not comprehensive. Fracture lines may be mistaken for superimposed bony septa or suture lines. The thin orbital floor may be obscured by other bones of the skull.

The common roentgen signs of blow-out fracture of the orbit are:

1. Fragmentation of the bony floor.
2. Depression of the bone fragments.
3. Prolapse of soft tissue into the maxillary sinus.

The most useful view for visualization of these fractures is the Water's postero-anterior projection or modifications of it. If the clinical impression of orbital floor fracture is not substantiated by this or other views, antero-posterior or postero-anterior laminagrams of the orbit are imperative. In fact, laminagrams should be done routinely if orbital floor fracture is suspected.

TREATMENTS

Once the diagnosis is established, prompt surgical reduction is necessary. The fracture must be reduced, any incarcerated muscle freed, and bone (or other material of like affinity) graft used in repair of the defect in the orbital floor.

CASE REPORT

On May 20, 1962, a nine-year-old was struck in the left eye with a regulation baseball. At the hospital, a diagnosis of a simple black eye was made and the patient was sent home. X-rays of the injured eye were reported as negative.

The patient was brought to our office the next day because of double vision and severe pain in the left eye. Examination revealed moderate ecchymosis and edema of the left upper and lower lids. The conjunctiva was slightly injected. The fundus was normal. Attempts to either elevate or depress the injured eye beyond the horizontal meridian

Received for publication, February 21, 1963.

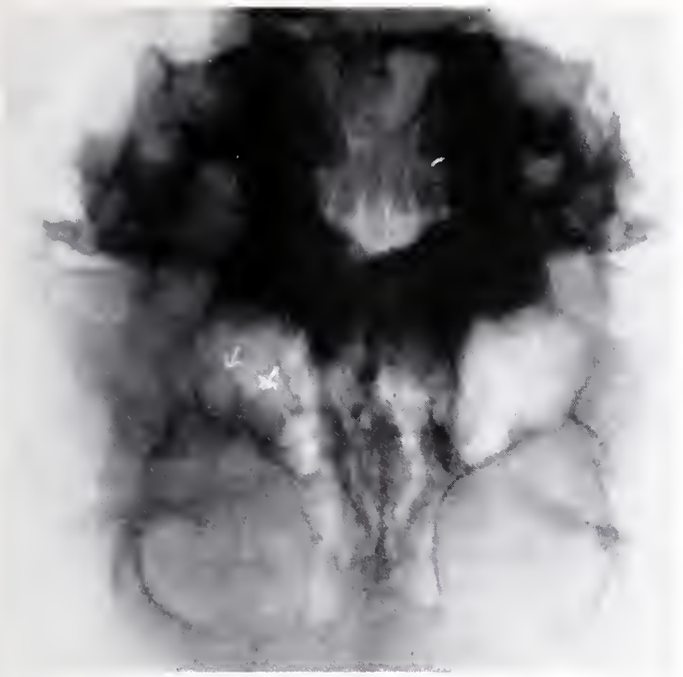


FIG. 1.—*Routine Water's view. Only abnormality is increased density in the upper part of left maxillary antrum (arrows). Left inferior orbital wall appears intact.*



FIG. 2.—*Laminagram at 15 cm level showing bony fragment displaced inferiorly from left orbital floor (upper arrow). The herniation of orbital tissues into the left antrum, suspected in Fig. 1, is clearly demonstrated (lower arrow). Compare with normal appearance on the right.*

caused excruciating pain in the eye. The traction test with forceps revealed a crucial malfunction—inferior and superior immobility of eyeballs. The diagnosis at this time was fracture of the left orbital floor.

The patient was admitted to the hospital for further x-rays and laminagrams. Ordinary x-rays remained negative, but serial laminagrams revealed increased density of the left inferior orbital rim with extension of this density into the superior portion of the left maxillary sinus (Fig. 1). In other films a curved bony fragment was seen below the left orbital rim (Fig. 2). The interpretation was fracture of the left orbital floor with inferior displacement of soft tissues and at least one bony fragment into the left maxillary sinus.

The patient was operated upon May 23, 1962, and the fracture near the infra-orbital fissure repaired. Both the inferior oblique and inferior rectus muscles were enmeshed in a herniated mass. Postoperatively, eye movements were normal in all directions of gaze and the diplopia and pain were gone.

DISCUSSION AND CONCLUSION

This case has not been presented to teach any reader how to manage orbital trauma, but rather to impress upon all physicians that while the prognosis in general is good for the vast majority of simple black eyes, an exhaustive examination is of the utmost importance. ■

1374 Nuuanu Ave. (96817)

Failure of blood clots to entrap red cells characterizes this rare inherited bleeding diathesis, which finally forced hysterectomy.

Hereditary Thrombasthenic Purpura and Pregnancy:

Report of Three Pregnancies in the Same Patient

H. E. BOWLES, M.D., R. B. JAFFE, M.D., and F. ROUKEMA, M.D.,* *Honolulu*

• *Hereditary thrombasthenic purpura is a bleeding disorder characterized by failure of the blood clot to entrap erythrocytes. The exact mode of its genetic transmission in this case could not be determined. The patient was successfully managed through two deliveries by conservative measures and copious transfusions, but hemorrhage after the third delivery required hysterectomy for its control.*

THE LITERATURE we have been able to peruse has been virtually devoid of references to pregnancy complicated by this condition, and a state of confusion seems to exist on the subject of blood dyscrasias in general. A mere obstetrician finds himself in deep water in attempting to report the behavior of a case of blood dyscrasia complicated by pregnancy.

The Committee for Clarification of the Nomenclature of Cells and Diseases of the Blood and Blood-Forming Organs made considerable progress in their conference in 1950, but a far more extensive international cooperative effort is needed. According to recommendations made by the committee,[1] it should be the general policy to use the term "hereditary" to apply to gene-produced disease; "familial" when the disease tends to occur in families and the mechanism of its occurrence is unknown; and "congenital" when the disease is present at birth, but is not necessarily gene-produced.

The patient referred to in this paper has been studied in detail by Professor E. E. Osgood[2] of Portland, Oregon, who states that both she and her sister have the condition referred to in his letter under the name of "hereditary thrombasthenic purpura." In this communication he stated further that this is a disease that most physicians have never heard of, in which the bleeding is similar to that in hemophilia and not like that in thrombocytopenic purpura. The only abnormal laboratory test is the clot retraction test. This shows good retraction but erythrocytes are not trapped in the clot.

Osgood calls attention to the fact that this disease is not adequately described in any book that he knows of. It is hereditary, and affects both sexes, but the bleeding is usually less severe than in true hemophilia. The trouble is apparently due to some defect in the quality of the thrombocytes, although they are adequate in number.

* From the Service of the Kapiolani Maternity and Gynecological Hospital, and the Straub Clinic, Honolulu, Hawaii.
Received for publication, February 25, 1963.

It is highly probable that some of the cases referred to in the literature as hemophilia-like, hemophilioid, pseudohemophiliac, and so forth, are actually cases of the same condition as occurred in this patient and her sister, but we can get nowhere by retracing our footsteps into the chaos of the past. The newer laboratory diagnostic techniques being developed, however, show promise of clearing up the true nature of some of these mysterious blood dyscrasias.

The hereditary condition occurring in our patient, and other members of her family, has some points of similarity to a blood dyscrasia first described by Glanzmann[3] in 1918 and called by him "hereditary hemorrhagic thrombasthenia" and recently reviewed by Larrieu[4] and colleagues. However, regarding this condition, Osgood[5] says the following: "most of Glanzmann's patients had an entirely different disease, but a few of them did show the failure of the clot to trap erythrocytes." This is the one characteristic feature we have found in the patient referred to in this paper and previously studied, along with other members of her family, by Osgood. A chronological review of our case with her three deliveries follows.

CASE REPORT

Pregnancy and delivery number one: A married white woman, gravida 1, para 0, with an EDC of May 29, 1959, was admitted to a military facility on May 5, 1959, because of weight gain of 27 pounds and swelling of her feet, legs, and hands. Pregnancy had otherwise been uneventful and without albuminuria or hypertension. In addition to weight gain and edema, the admission was for a work-up in regard to a history of bleeding tendencies in the past, manifested by severe menorrhagia and prolonged bleeding from minor cuts, tonsillectomy, tooth extractions, and hymenotomy. The patient's mother and a sister had shown similar bleeding tendencies, and had been carefully studied by Professor E. E. Osgood of the University of Oregon School of Medicine.

Tests carried out at the time of her admission on May 5, 1959, showed no abnormal values. She was admitted in active labor on May 26, 1959, and the blood bank, previously alerted, made fresh whole blood available. Membranes had ruptured spontaneously, at 11:30 P.M., May 25. Contractions began at 3 A.M. May 26, continuing actively until the cervix was 5 cm dilated at 7 A.M. Continuous caudal anesthesia was begun at that time. Thereafter, labor failed to progress normally and caudal anesthesia was discontinued at 12:30 P.M. Vaginal examination at 2 P.M. revealed a deflexed posterior presentation (confirmed by x-rays) but with more than adequate pelvic room. As the patient was fatigued but well hydrated, she was given morphine sulphate, grains one-quarter, hypodermically and rested well until 5 P.M., May 27. Spontaneous rotation of the posterior occipital presentation to an anterior position occurred, and she was delivered at 10:54 A.M. of a viable girl, 7 lbs. 7 oz., by low forceps under resumed caudal anesthesia, after midline episiotomy. Total labor lasted 31 hours.

Immediately after placental expulsion (modified Credé method), there was "heavy uterine bleeding from several sinuses in the lower uterine segment which could be seen when looking for lacerations." There were no lacerations of the cervix or vagina and there was little bleeding from the episiotomy. Blood loss was estimated at between 800 and 1000 cc. The uterine fundus responded to massage and intravenous and intramuscular oxytocics. She received two units of fresh whole blood, one of which had been started running slowly at the time of delivery. She also received 1000 cc of 5% glucose in distilled water with one cc of pitocin, 100 mg of hydrocortisone, and 50 mg of vitamin K.

Convalescence was uneventful. There was no further bleeding and the episiotomy healed without delay. She was discharged on the fifth postpartum day with a hematocrit reading of 37.

Pregnancy and delivery number two: On April 8, 1960, the patient reported to the Straub Clinic under the Medicare plan. Her general health had been good since her previously documented delivery but her menses had been as heavy as formerly. After an uneventful prenatal course complicated only by moderate hypochromic anemia, she was admitted to the Kapiolani Maternity and Gynecological Hospital at term and in active labor on July 4, 1960. Fresh, whole, siliconized blood was immediately made available by previous arrangement with the Blood Bank of Hawaii. After a first stage labor of two hours and twelve minutes, delivery occurred spontaneously under light nitrous oxide analgesia. Fresh blood transfusion was begun just prior to delivery of an apparently normal girl weighing 8 lbs. 5¾ oz.

Midline episiotomy was repaired under 1% xylocaine local anesthesia. Immediate postpartum bleeding was negligible. After an interval of 39 minutes, it was necessary to remove manually a placenta partially adherent above the internal os. Cyclopropane anesthesia was given. At this point, severe bleeding occurred, and the uterine cavity, cervix, and vagina were explored. No lacerations nor retained placental fragments were found.

Despite the speeding up of the blood transfusion, plus intravenous ergotrate and pitocin drip, the blood pressure dropped to 70/50 at one and one-half hours postpartum and bleeding continued. After the eighth unit of blood, cortisone acetate

injections were begun; a total of 1,325 mg were given over the ensuing seven days. The uterine eavity and vagina were now firmly packed with two-ineh plain gauze strip paeking. Bleeding was eontrolled, blood pressure rose and liberal Aehromyein eoverage was given. A total of 11 units of fresh, silieonized blood was given. There was no untoward reaction. Several fibrindex samplings were normal and a quantitative fibrinogen level at five hours postpartum was betwen 100 and 200 mg per eent. The hemoglobin figure 24 hours postpartum was 13.1 gm.

Paeking was removed 24 hours after insertion and no further bleeding oeeurred. Uneventful eonvalescence ensued and she was diseharged on the fifth postpartum day. Subsequent menstruation was heavy as usual but her health seemed good otherwise, and no aeeidental injuries oeeurred.

Pregnancy and delivery number three: On August 15, 1961. the patient reported having menstruated last on April 20, 1961. Hemoglobin was noted to be 11.8 grams and hematocrit 36 per cent. The usual precautionary high protein diet with oral iron was given throughout the pregnancy. The estimated due date was January 25, 1962. She reported on January 18, 1962, that she felt as if labor was about to commence. Vaginal examination with aseptic precautions revealed a ripe cervix 75 per eent effaeed, 3-4 em dilated, and with bulging membranes, and the fetal head at station 0. Labor eommeneed approximately at 8 A.M. on January 24, 1962.

The blood bank was immediately alerted and went into action with a large list of donors who were becoming restive by this time, having been on eontinuous eall for at least a month.

Amniotomy was performed at 1 P.M. as eontraetions were still desultory. Active labor ensued without oxytocies, and whole fresh, siliconized blood transfusion was begun at 6:15 P.M. January 24, with the external os 4-5 em dilated. The first stage of labor lasted about seven hours from the time of amniotomy. The seeond stage of labor was normal and lasted about ten minutes. With nitrous oxide and oxygen analgesia, spontaneous delivery of an apparently normal female infant weighing 7 pounds oeeurred at 7:44 P.M. January 24, in ROA position, with no episiotomy. One small mueosal split oeeurred in the midline of the perineum, but no bleeding oecurred from it and it was not sutured.

Placental separation seemed to have oecurred, but as the placenta seemed to be held at the external os for ten minutes, and the uterus tended toward bogginess, pitoein drip was added and blood transfusion speeded up. Despite the occurrence of an adherent placenta at her second delivery, there was no evidenee of adherence at this time. Exeessive bleeding continued until two hours postpartum, by whieh time blood loss was estimated at 2,000-2,500 cc and she had received 2,000 ec. At no time did shoek ensue and she was returned to her room in good condition and without paeking the uterus. A total of four and one-half units, 2,250 cc, of fresh, silieonized whole blood had been given.

The remainder of the hospital stay was uneventful and she was discharged on January 29 1962, (fifth postpartum day) with normal loehia, afebrile, and apparently in good eondition.

On February 1, 1962, the seventh postpartum day, she was readmitted at 6:55 A.M., having soaked 16 vulvar pads with blood sinee midnight. More fresh, silieonized whole blood was obtained, transfusion and intravenous oxytoeie drip were begun. Despite this, bleeding continued and at 2 P.M. February 1, 1962, the uterus and vagina were explored and no single bleeding point eould be loeated. The uterine cavity and vagina were firmly paeked with two-ineh gauze strip paeking. Blood transfusion and intravenous oxytocic infusion were eontinuously maintained.

Complete exchange transfusion was considered, but since bleeding continued through and around the firmly packed uterus and vagina, immediate total hysterectomy was done, under a eombination of intravenous sodium pentothal, eyelopropane, nitrous oxide, and oxygen, A normal pulse and blood pressure were maintained throughout the operation which she stood surprisingly well.

In order to forestall possible future surgieal intervention, ineidental appendeetomy was done. It was eonsidered advisable on the premise that she might be caught at some future date in eircumstances where fresh, silieonized blood would not be available, should an attaek of appendicitis oeeur.

During this second admission, a total of 12 units of whole, siliconized blood was given, or a total of 16½ units since her third delivery prior to this readmission.

On the seeond postoperative day, the hemoglobin reading was 13.3 gm and hematocrit 44 per cent. No bleeding followed the hystereetomy. Convalescenee was smooth and relatively afebrile. Primary healing oecurred, and she was diseharged on the ninth postoperative day (16th postpartum day).

As on previous occasions, there was no fibrinogen deficieney. It was of note in regard to venous blood drawn shortly following her readmission that normal elotting oceurred within ten minutes. At 24 hours the elot was firm and constituted 21 per eent of the total volume, serum 56 per cent. However, 23 per eent of total volume eonsisted of free erythrocytes. This latter gives the elue and brings out

the distinguishing diagnostic feature of this blood dyserasia as brought out by studies made by Osgood on this patient and others of her family.

The microscopic examination of the uterus showed the following:

> A: Sections reveal blood and fibrin incorporating a few chorionic villi and fragments of decidua. B: Sections of uterus reveal normal hypertrophy of the myometrium found in pregnancy. The surface next to the uterine cavity is partly covered by blood and degenerating decidua. In one section there are a number of dilated veins and vascular sinuses near the surface, some of which contain thrombi. Sections of the cervix show edema and increased vascularity. There is an infiltration of polymorphonuclear leukocytes near the surface, especially in areas where the epithelium is degenerated. C: The appendix shows submucosal fibrosis but is otherwise unremarkable.

This patient has remained well and is now residing in California. Detailed blood studies have not yet been carried out on the older two daughters born on the occasions herein reported.

The third child showed many petechiae at birth on January 24, 1962. On January 25, a few more petechiae were noted. On January 29, it was seen that the original petechiae were fading. A few new ones were noted, and there was a slightly blood-tinged stool. On February 1 (8th day), blood from the heel yielded the following results: "Duke bleeding time 1½ minutes, Duke clotting time 4½ minutes. Blood morphology: Red blood count, white blood count, and platelets appear normal." On February 2, the following report was obtained: "Clot forms normally in 8 minutes; firm in 12 minutes; begins to retract in one hour; at 24 hours clot appears firm. Clot 26 per cent; serum 48 per cent; free RBC 26 per cent."

All three girls seemed to be healthy in appearance at birth and when last seen in Honolulu.

SUMMARY AND CONCLUSIONS

Medical literature pertaining to blood dyserasias is in general confusing, and there is need for continued efforts for clarification on an international exchange level.

The development of new laboratory techniques makes it almost impossible to compare the ease of today with a seemingly similar ease of former days.

Hereditary thrombasthenic purpura is a blood dyserasia about which little has been known heretofore, and it can be differentiated from blood dyserasias resembling it superficially, by failure of a well-formed blood clot to trap and retain erythrocytes.

The condition is hereditary and affects both sexes, but bleeding is usually less severe than in hemophilia. The difficulty is apparently due to some defect in the quality of the thrombocytes although they are adequate in number.

A family group presenting hereditary thrombasthenic purpura is discussed. The group consisting of the patient together with her mother and two sisters has been studied in detail by Professor E. E. Osgood, University of Oregon School of Medicine. A résumé of three pregnancies resulting in the birth to one patient of three girls is presented.

Adequate laboratory facilities, complete cooperation between patient, physician, blood bank, donors, and hospital personnel are basic essentials if these cases are to be recognized and the patient saved. A virtually unlimited supply of freshly drawn siliconized whole blood with commencement of the transfusion prior to completion of the second stage of labor is the key to the salvage of the mother.

It will be necessary that the children of this patient be studied with a view to their future survival.

Cortisone therapy was given empirically following this patient's first two deliveries but not with her third. It is not considered efficacious in this particular blood dyserasia.

Note: Acknowledgment is hereby extended to Professor E. E. Osgood of the School of Medicine of the University of Oregon, who furnished key information and advice, and to Leon E. Mermod, M.D., of the Blood Bank of Hawaii, who, along with the Blood Bank and Kapiolani Hospital personnel, figuratively sweated blood day and night in the over-all care of this patient. Nor must we omit thanks to the large list of donors who remained on call day and night toward the latter part of these three pregnancies in this patient, and to all who gave timely advice and help in her hours of need. ■

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The President's Page

Most of you have no doubt heard of the WICHE program, but I believe that only a few know what it really is, what it does, and to what extent Hawaii participates. Therefore I will follow up my last dissertation on the problems of meeting the medical manpower needs of the West with an over-all look at the WICHE program as it pertains to medical education.

In 1950, special advisory committees appointed by the Governors of the western states studied the supply of and future demands for manpower in dentistry, medicine, public health, and veterinary medicine, and the facilities available in the West for training personnel in these fields. After these studies, a plan was formulated by which states which had no facilities for professional education could send their young people for training to other western states with such facilities. This regional Student Exchange Program began in the academic year 1953-54, when five states sent a total of 41 students to professional schools in other western states. In 1963-64 there are 450 participating medical students, 14 of them from Hawaii. At present all accredited schools of medicine, dentistry, and veterinary medicine in the West participate in this program.

In general, this is how the plan operates. A state with no medical school makes its own eligibility rules for prospective students whom it agrees to support, and decides on the number of such students that it can afford to support. Then for each student accepted by a professional school under the program, the home state pays an agreed-upon fee to help make up the difference between the tuition paid by the student and the cost to the school of educating him. In medicine, this fee has been $2,000 a year. The exchange student pays only the resident tuition and in the case of private schools there is a comparable reduction in their standard fees.

This program is ideal in that it offers maximum freedom for all parties concerned. Each student has the right to apply for admission to the professional school of his choice. The schools, in turn, maintain their own admission policies which determine whether a prospective student is rejected or accepted, and the "sending" states set up their own standards for eligibility and determine the amount of money available for this program.

The academic year 1960-61 saw the first two medical students from Hawaii participating in this program. In 1961-62 this increased to eight and at present there are 14. The only requirement for a student to be supported by our state is that he or his parents be residents of Hawaii. In case there are too many applicants in proportion to funds available, a committee passes on each candidate and gives first priority to those with the greatest need. Three states, Nevada, Wyoming, and Arizona, require that their students return to their home state to practice—one year for each year of training—or face certain financial penalties. However, a conference on the Student Exchange Program of WICHE in San Francisco this year

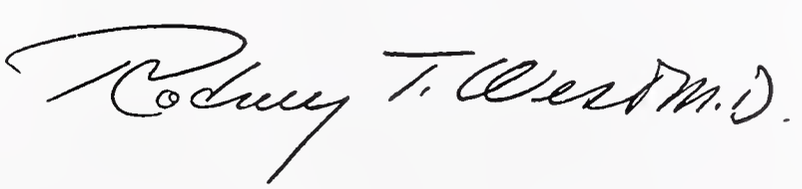
deplored such a policy as being unfair to both the student and the "receiving" states. It was felt that a state has the responsibility for providing higher education without restrictions on future activities of students. WICHE is *not* a scholarship program.

The 14 students from Hawaii are at present attending six of the western medical schools (USC 1, UCSF 2, UCLA 1, Colorado 5, Oregon 3, Washington 2). Only two states (Nevada and Alaska) have fewer participants than Hawaii. Arizona has the largest, with 75 students. This number will no doubt be drastically reduced when their new four-year medical school opens in Tucson. New Mexico, which plans to start a two-year medical school in 1964, has 32 participants. Then there are: Idaho with 44, Montana 19, Wyoming 17, Nevada 7, and Alaska 6.

As new educational facilities become available, WICHE in its present form will no doubt begin to phase out and more emphasis will be placed on educating the optometrist, the dental hygienist, the physical therapist, the occupational therapist, the laboratory technician, the nurse, and others who are going to have to help meet the increasing need for health care. The new medical educational facilities which are being acted upon on or contemplated are: Colorado to increase from 85 to 96 the number in the junior and senior classes, a new two-year school in New Mexico, a new four-year school in Arizona, accreditation of the former California College of Osteopathy as a medical school, the doubling of the capacity of the School of Medicine at UCLA, a new four-year school in San Diego, plans to re-establish the Presbyterian Medical Center (formerly affiliated with Stanford) as a medical school, new facilities at Oregon, Washington, and Utah; and, of course, we know of the recent interest in a two-year medical school in Hawaii. Idaho, Montana, Wyoming, and Nevada are at present undergoing an 18-month study of their medical education needs and resources. These states have a combined population of 1,957,000 but are without any major center which might be the site for even a four-state cooperative medical school. In spite of all this seeming abundance of new and projected facilities the facts are these: It is estimated that the western states need 2,300 doctors a year. At the present time the West is educating only 600 a year. Even if this is increased to 800 a year with new facilities, it still leaves a huge deficit of 1,500. Hawaii's need for a net gain of 25-30 new doctors a year is really small even when compared to the states that now have medical schools.

Some fear that with the fierce competition and the greater need for places in medical schools and with the decline for the need of WICHE that Hawaii will gradually be squeezed out of the state-supported schools which will be overburdened with applicants from their own constituents. However, at the WICHE meeting in San Francisco it was felt that the admission of medical students to state schools would and should always be based on quality and not on residence and that these schools would never be closed to the better students from any state. To do so would lower the level of education in that school.

All this brings us right smack up against the proposition, do we need, can we afford, and can we organize a proper two-year medical school, or a substitute for it, here at the University of Hawaii? Between now and the next issues of the HAWAII MEDICAL JOURNAL these questions may become even more burning than they are now. If so, and if I deem the timing to be proper, I may express my ideas on this subject, whatever they might be worth. Anyway it behooves us all to become more familiar with the medical educational needs and the facilities available to our state, and it is with this in mind that I have presented the above.



HAWAII MEDICAL JOURNAL

Editorials

What Price Prestige?

The University of Hawaii appears to have decided about three years ago that it ought to have a medical school, and to have planned its acquisition in three phases: first, the establishment of a biomedical research institution, which was accomplished during 1962; second, the establishing and public acceptance of the academic facilities of a two-year medical school, which are being attempted at the present time; and third, presumably, the actual opening of a medical school as such.

Phase two of this operation first came to public attention in February of this year, when a two-man study team (Drs. Richard Young and Walter Wiggins) came here to study the feasibility of establishing a two-year medical school at the University of Hawaii. They thought it would be feasible, so $120,000 was secured from the Commonwealth Fund, and Dr. Robert D. Tschirgi (M.D. and Ph.D.), Academic Assistant to the President of the University of California, was commissioned to conduct the feasibility study itself. This he began to do on July 1, 1963.

On October 18, 1963, the study was publicly unveiled at a luncheon hosted by the University of Hawaii for several score physicians and leading citizens, at which Senator Nelson Doi and Dr. Tschirgi spoke of the need and the desirability and feasibility of teaching medical courses at the University of Hawaii.

Senator Doi said that the number of practicing physicians per 100,000 population in Hawaii had declined from 132 (the national average) in 1958 to 87 (118, according to Dr. Richard K. C. Lee!) in 1962, and that 150 to 250 more doctors would be needed by 1970 to fill Hawaii's medical manpower needs. We should follow the lead of other states, he said, by educating some of these ourselves. Why the present net annual gain of doctors (74 new licenses were issued in 1962) would not suffice, he did not say.

Dr. Tschirgi said that a medical curriculum at the University would promote medical research and attract both students and teachers to Hawaii; that it would greatly enhance the University's prestige; that it would enable Hawaii to discharge its obligation and responsibility to bear a share of the burden of educating the physicians it needs.

He acknowledged freely that a medical school is by far the most expensive operation for which institutions of higher learning are responsible. But an Interdisciplinary Curricular Program leading to the Master's Degree in Biological Sciences would include all the courses customarily taught in the first two years of medical school, along with a good many others. It would require only a little supplementation of existing classrooms and faculty. It would train students in other biological fields than medicine to a considerable extent. But its graduates would be eligible to admission to medical schools with "advanced standing"—by implication, third-year standing.

Financing of this program (unlike the financing of the existing smaller state medical schools, according to the recently published report of the A.M.A.'s Council on Medical Education and Hospitals) can be largely from Federal funds. Will Federal support lead to Federal control, asked Dr. Tschirgi. He quoted the President of the University of Chicago: "This warning is indeed well taken . . ." but, he added, don't worry about it too much.

The clinical orientation so desirable during the first two years of medical school would be supplied, hopefully, by the town rather than the gown, in existing private hospitals rather than in a University Hospital, Dr. Tschirgi said.

To our way of thinking, a two-year medical school, by whatever name, in a state with a population of 600,000 (nearly half of them of school age or younger), which currently sends about 30 medical students to the mainland each year, of whom probably not over ten would choose to remain here for the first two years of medical school, is an unthinkable extravagance. Enhancement of the University's prestige by this method carries too large a price tag even if the bill is paid out of Federal funds instead of State. It's still money—*our* money.

We have no medical manpower problem. As for the argument that Hawaii students may find entry

into mainland medical schools increasingly difficult in the years to come, we think this is fine—it will insure that only the most capable ones are able to become physicians.

If there are financial obstacles to medical careers for Hawaii's students, let us relieve them as the WICHE program has done, on an individual basis.

If we are to have a two-year medical school in Hawaii, let us at least (1) establish the need, (2) explore the alternatives, and (3) justify the extremely high cost.

High School Football

Dr. Frank Tabrah documents elsewhere in this issue the physical risks associated with football practice and play at two rural schools, a local high school and a private boys' preparatory school, for which he is team physician. He considers some aspects of possible reasons for the apparently high incidence of injuries, and some drawbacks presented by football as a school sport.

He does not emphasize the limitations of football from the standpoint of the small proportion of the student body that is actually able to participate in it. He does not stress the more serious or even lurid accidents that occasionally occur, nor even the infrequent but none the less serious accidents involving permanent partial disability of some degree.

Nor does he lay any stress on the economic urgency of maintaining a football program, once it is begun and the school has begun to depend on it as a source of revenue.

It is to be expected that the many ardent proponents of high school football will feel he has, on the other hand, given far too little credit to the positive values of the game. He does list some of these, however, and we would urge those who reply to him to address themselves with care to his specific arguments and objections. The justification for a high risk of disabling and potentially serious injuries to high school students—if such a risk does in fact exist—should rest on a solid foundation.

Fluorides in Aerospace Medicine

Among the problems of space flight discussed in this issue by Lieutenant Colonel Moser, weightlessness presents—it is now feared—one particularly serious and unexpected problem: osteoporosis. There is reason to believe that even a week of weightlessness may result in the withdrawal of so much calcium from the skeleton that "pathologic" fractures may occur.

It has been suggested that the fluoroapatite bone structure in persons who have been adequately supplied with fluorides in their drinking water may be far more resistant to this demineralization of disuse than plain ordinary bone containing only calcium and phosphorus.

If this proves to be so, astronauts may have to be recruited, for a while, from areas where the nutritional value of the public water supply is either naturally or artificially up to par with respect to fluorides.

Let "George" Do It

Perhaps all the sins and evils that we and our country have fallen heir to are the result of our national attitude of "let George do it." (Many would even go so far as to paraphrase it as "Let JFK Do It!")

Within our own Chapter, this is a serious matter up for consideration soon at our annual election of officers. We are trying to find "Georges," new Georges, to relieve us old Georges. It is more than somewhat shameful that within any organization, criticism will come aflying at the drop of a hat, but few will throw a hat into the ring and run for the office of George. But poor George—he is offered all sorts of hollow promises of support, which evaporate when he most needs them.

THE AMERICAN CONSTITUTION

The basis of the American Revolution was the revolt against tyranny. The makers of the American Constitution, of whom Tom Paine was the clearest thinker, knew full well, however, that even a representative form of republic, holding to all the principles of a democracy, can drift into a tyrannical form of government, the tyranny of the majority. How did they attempt to build into our Constitution the safeguards to prevent this?

To begin with, the original call for delegates to the Constitutional Convention was a concept new to civilization. It established the right of men as free individuals in a community to determine for themselves the form of their governing body. This was in contradistinction to previously established governments given *to* the people, more likely *over* the people, by a conqueror, by a secular individual or body of men, or by the Grace of God as dispensed by a powerful clergy. This "American" way of establishing a government of the people, by the people and for the people presumed one very important thing: *all* the people participated. They just didn't leave it up to "George" to do the job!

Then, to keep the representative majority from overriding any minority, the wise founders of our country specified that the government should not have the right to alter itself; alterations should be initiated by a constitutional convention of delegates from the nation in its *organized* character.

Herein is where we have lost our birthright: we have let the Executive and the Judiciary to impose upon the Congress their will to alter the government.

The framework of the Constitution abounds in checks and balances to keep the power of the majority within limits. With the passage of history, however, we have lost the vision of our ancestors and have allowed these safeguards to be whittled away. It has come to the point where minority groups, and individuals, are even being deprived of the freedom to overthrow the majority by elections—because public power and public money under majority control are permitted to be exercised in behalf of its self-perpetuation. What few and small privileges an individual or a minority has, are there by *courtesy* of the majority, *not* as a protected right. If the majority is greedy, vindictive, or ruthless, the dice are loaded and there is no appeal.

IT IS OUR OWN FAULT

As stated above, the concepts of government formulated by our founding fathers presumed the active, intelligent participation of all the people. Success of the experiment depended upon this wide base of interest.

This presumption applies with equal force to lesser governments—that of the AMA, the HMA, the HCMS, and, for us GP's, our Hawaii Chapter of the AAGP.

We have no right to complain about the takeover by the majority—we have allowed it to happen by selling our birthright in exchange for the comfort of watching TV at home (and falling asleep at that!), while letting George run the meeting and set the policies that we will fuss about when it is too late to do anything about it. We are not a nation of sheep—we are a nation of Shmoos: creatures of low centers of intellectual gravity, the result of slumping into basket chairs. We allow a majority vote of 70, against an opposition vote of 68, set the policy for a body of nearly 400 members.

This is indeed a "let George do it" attitude. It obviates completely the purpose of a representative form of democracy. It allows for bigotry and wrong thinking to hold sway. At best, it places the well-meaning Georges in the position of doing what they think is for the good of all; it places the burden on their shoulders when, in fact, they would be only too glad to be assisted and guided, and have the burden shared.

It is disheartening to hear criticism freely given in the hallways by those who always refuse to stand up and be counted on the floor of debate, and particularly those who refuse, "for personal reasons," to run for office or accept an appointment.

Unless we soon quit this immature and irresponsible practice of "Let George Do It," we will never withstand the onslaught of Socialism.

J. I. FREDERICK REPPUN, M.D.
Secretary-Treasurer

HAWAII MEDICAL JOURNAL

This Is What's New!

• The ruby laser, the intense red beam used to penetrate outer space, can also be used as a microsurgical instrument. By sharply focusing the beam, small **perforations of the cell walls of living algae** have been produced without causing irreversible damage. (*Science* [July 5] 1963.)

• A view of 18 cases of **staphylococcal enterocolitis** following surgery revealed that **gastrointestinal carcinoma** of some type was the most common preoperative diagnosis. It was the author's conclusion that **methicillin** or **sodium oxacillin** were the antibiotics of choice and in no patients were any of the staphylococci resistant to these two agents. (*Ann. Surg.* [July] 1963.)

• Treating a child's streptococcal **sore throat** by a ten-day course of **penicillin** is generally regarded as the best way of preventing **rheumatic fever.** Taking a penicillin tablet daily for ten days is the most painless and economical way of taking the drug. Follow-up visits, however, indicate that half of the children **stop taking the drug** by the **third** day and three-fourths of the youngsters have discontinued the drug by the sixth day. **Long-acting penicillin by injection** may still be the preferred route.

• The **American Journal of Medicine** editorializes on **future need for trained physicians.** Three reasons for this increased need are given. First, increase in total population, especially the very young and the very old, in whom medical needs are usually higher. Second, increased complexity of medical services with improved levels of general as well as medical education, with increased demand for medical service. Third, "the drain upon the physician population imposed by an increasing need for medical teachers and especially medical investigators." The fraction of physicians devoting their time exclusively to private practice has steadily decreased since 1940. During the same period of time **hospital-employed** physicians have increased approximately three times and the number of physicians in **teaching and research** has also increased approximately three times. This trend almost certainly will continue. The only solution, according to the Dean of a New Jersey medical school, is to train many more physicians over the next decade. Also advised are more first two-year medical schools. (*Am. J. Med.* [July] 1963.)

• Further studies on **alpha-methyl Dopa** as an **antihypertensive** agent indicate few significant side effects and certain special advantages when compared to other antihypertensives. The drug was used in 25 hypertensive patients, without evidence of significant toxicity. Hemodynamic studies indicated that the fall in arterial pressure was due primarily to reduction in peripheral resistance, without change in cardiac output. Renal blood flow and glomerular filtration rate were unchanged and there was no sodium diuresis. In fact, in two of the patients there was mild sodium retention. The investigators agree that alpha-methyl Dopa was intermediate in potency between the reserpine-thiazide combination and the more potent ganglionic sympathetic blocking drugs. (*Circulation* [Aug.] 1963.)

• A group of New Yorkers have administered **tetracycline** orally and intramuscularly to patients suspected of having **gastric carcinoma.** The gastric contents are aspirated and sediment studied for **fluorescence** with a Woods' light. They conclude that the technique seems to be a useful method in differentiating carcinomatous and non-carcinomatous gastric lesions, and that the IM route has some advantages in some patients because it shortens the testing period. They also suggest that the fluorescence may have advantage in the examination of frozen sections at the time of operation. It was also noted that the anti-cancer drug, 5-FU, inhibited the fluorescence, but that this could not be used as reliable indicator of probable clinical remission or prognosis. (*Gastroenterol.* [July] 1963.)

• A Boston surgeon reviews the medical and ethical aspects of the **hopeless case,** noting that "hopeless" cases of yesteryear are not always the hopeless cases of today, and concludes that there are no "hopeless" patients, only **hopeless doctors.** (*Arch. Int. Med.* [Sept.] 1963.)

• Of 100 patients subjected to anterior temporal **lobectomy** for **epilepsy,** over **half** were **free of seizures** or almost so (53 per cent). Only 17 per cent showed little or no improvement. In the great majority of patients histological lesions were found, with temporal lobe sclerosis being the predominant lesion. (*J. Neurol., Neurosurg. Psych.* [Apr.] 1963.) ■

FRED I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii

This is the forty-sixth installment of In Memoriam—Doctors of Hawaii.

John Gaunt Brooks

John Gaunt Brooks was born in Montgomery County, Tennessee, October 5, 1840. With his family he moved to Lovelaceville, Kentucky, in 1851 where he received his elementary and high school education.

At the onset of the Civil War he enlisted as a private in the Third Kentucky Volunteers, Confederate Army, under General Lloyd Tighlman. In 1863 his regiment formed a part of General N. B. Forrest's Corps, and he fought in the battles of Shiloh, Baker's Creek, Harrisburg, Vicksburg, and Jackson. For the last three years of the war he was orderly sergeant for his company.

At the end of the war he returned to his father's farm to try and get enough money to become a doctor. During the autumn and winter of 1865-1866 he attended Eureka College, Eureka, Illinois. The following June he began his study of medicine with Dr. Joseph W. Thompson of Paducah, Kentucky, and in the winter of 1866-1867 he attended lectures at the University of Nashville. Going to Philadelphia, he enrolled for a summer course in Jefferson Medical College, took the ensuing winter course and graduated in March, 1868.

Dr. Brooks first began his practice in partnership with Dr. David P. Juett at Lovelaceville, and on January 1, 1869, he moved to Paducah. In the winter of 1870-1871 he was in charge of quelling an epidemic of smallpox, and during this same period he was elected City Physician. It was in this capacity that he succeeded in getting the City Council to build a hospital.

In the fall of 1872 Dr. Brooks came to Hawaii where he became a government physician for the islands of Maui and Lanai. He was associated with a fellow Kentuckian, Dr. J. B. Saunders of Wailuku, Maui, in a partnership which lasted until Dr. Saunders' death in August, 1873. A few months later (November 26, 1873) Dr. Brooks's business card appears for the last time in the *Hawaiian Gazette,* and he must have left shortly thereafter.

By 1874 he had returned to Kentucky and again had an office in Paducah. On May 29, 1875, he married Miss Marye King, daughter of ex-Governor John Q. A. King. The Brookses became the parents of four sons and a daughter: King, James, Overton, John and Ethel (Mrs. Koker).

In addition to the demands of a very heavy practice, the doctor served four years as a member of the City Council and another four years on the Board of Education for Paducah. For 27 years he was a director of the City National Bank of Paducah.

But it was within his profession that he was most active. Together with Drs. Joseph Thompson and James Singleton, Dr. Brooks organized the Southwestern Kentucky Medical Association in 1871 and served as its president in 1882. About 1876 he led the way in organizing the Paducah Medical and Surgical Club and later became its president for a term. In 1883 he founded a private sanitarium which he maintained for ten or twelve years when the work became so heavy he was forced to discontinue it. In 1887 he was President of the Kentucky State Medical Association. He was also a member of the McCracken County Medical Society, the Mississippi Valley Medical Association, the International Congress, the American Anti-Tuberculosis League, and the American Medical Association. He was the leader of a drive to build the Riverside Hospital in Paducah, which opened in 1905.

Dr. Brooks continued his active practice until June, 1912, when he retired. On September 25, 1915, the doctor died in a sanitarium at Louisville, Kentucky, at the age of 74.

He was a member of the Paducah Lodge No. 127, F. & A. M. and a member of the Protestant Episcopal Church.

The following is taken from a memorial to Dr. Brooks read before the Southwestern Kentucky Medical Association: "Unlike some successful men, he was modest while firm in his convictions, but was never dogmatic. In all of the relations of life he was a courteous, splendid, chivalrous gentleman. His life is an inspiration to us, his surviving associates, to reach the highest degree in point of qualification and service. Our Association has during the forty-five years of its existence had many bright names upon its roll, many of whom were known personally or by reputation throughout our State. Some have won national reputation. In point of ability, enthusiasm, zeal and sincerity he was excelled by none. Always he did his best. Can mortal do more?"

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Book Reviews

★Internal Medicine in World War II, Vol. II, Infectious Diseases

Edited by Colonel John Boyd Coates, Jr., MC, USA; 649 pp., $6.75, Office of the Surgeon General, Department of the Army, U. S. Government Printing Office, 1963.

THIS IS the twenty-first volume of a series on the medical history of World War II; another volume will conclude the subject of infectious diseases. Several of the chapters are written by authors of renown, and all chapters are well written.

This volume is far more than a compendium of statistics and a record of what the Army did to detect and treat diseases. Descriptions of clinical manifestations of diseases inadequately discussed in American textbooks—e.g., typhus, cutaneous diphtheria, dengue—contain valuable information. Of many excellent chapters, those on the typhus fevers (80 pages, by Zarafonetis) and on neurotropic virus diseases (by John Paul) are outstanding. Almost all authors avoid the temptation to begin with pre-war history and continue with post-war developments.

There are few errors. In the treatment of malaria, Perrin Long summarily dismisses plasmochin in one sentence; however, Harry Most rectifies this lapse in a long, highly informative section on antimalarial drugs. Finding mononucleosis in the chapter on respiratory diseases and then reading the erroneous statement—"nearly 20 per cent of patients have no abnormal lymph gland enlargement" were painful for me.

The book's superlative chapters on malaria (144 pages) and on typhus could by themselves justify the book's purchase, but there are also excellent chapters concerning other diseases; and, in addition, the historical and statistical data are of unique value.

ROBERT J. HOAGLAND, COL., M.C.

★The Practice of Country Radiology

By Donald de Forest Bauer, M.D., C.M., M.Sc., 260 pp., $11.75, Charles C. Thomas, 1963.

THOUGH THE TITLE suggests that the book was written for physicians practicing in outlying communities, in actuality, it is written for the radiologist only. The author has discussed in delightful detail and with humor the multiple perimeters of the practice of the specialty of radiology. The Resident is seldom taught how to set up an office or establish a new department in a small hospital. He frequently has little knowledge and certainly limited experience in the thousand and one detailed items and decisions that are so required.

The author covers these admirably. He delves into his philosophy of practice, ethics, equipment, repairs, bookkeeping methods, and insurance, and physician relationship. How he has solved the various situations and his recommendations is material not found in any other text or course of teaching. It is basically written as though it were confined to the radiologist practicing in the smaller communities rather than the large city. There is no question that the radiologist who is practicing his specialty in any situation will find many points of interest and benefit, whether he is well established with a hospital, group, or commencing a new practice. This book should be required reading for all senior radiology residents and it is highly recommended to radiologists in all veins of practice.

GEORGE HENRY, M.D.

★ means highly recommended.

This Air We Breathe

By Clarence A. Mills, M.D., Ph.D., LL.D. (Hon.), 172 pp., $4.00, The Christopher Publishing House, 1962.

DR. MILLS IS AN "ANGRY MAN"—one so impressed with the danger and injustice of continuing to permit pollution of the air we breathe that he has devoted much of his later life to the investigation of the causes and effects of air polluted by either exhaust gases or cigarette smoke.

His documentation of effects, supported by tables of statistics, is impressive. He is the first writer I have read who has investigated the statistical effect of the "number of miles driven in traffic."

No one can long deny the pernicious effect of smokes (in the broad sense) on pulmonary disease, and a good case is made out for cardiac disease also.

Remedies are suggested—all of these extremely difficult and expensive, except one: forbidding the advertising of cigarettes. I do not see how anyone not in the cigarette business can object to that!

One consideration does not seem to have occurred to him—perhaps the kind of person who smokes cigarettes is in some way related to his susceptibility to lung cancer.

Pollution of water by sewage and detergents, and of air by smoke, are serious matters now, and growing steadily worse. The suburbanite escapes during the night and weekends, but loses by his long drives in traffic.

Like the shocking death rate from traffic accidents, the situation will have to get a lot worse before anything basic is done.

More power to Dr. Mills!

H. L. ARNOLD, SR., M.D.

★Alone No Longer

By Stanley Stein with Laurence G. Blochman, 350 pp., $5.00, Funk and Wagnalls Co., Inc., 1963.

THE TRIUMPHANT STORY is here told of a man whose life work is the spreading of a light which he cannot see. For Stanley Stein is blind, as a result of what he would have us call "Hansen's Disease"—and in his physical darkness he edits "The Star," the publication of the patients at Carville, Louisiana, which "spreads the light of truth" around the world. To him, Dr. Robert Cochrane, one of the world's leading leprologists, has said, "You have made a greater contribution to the lay understanding of leprosy than any other layman." Physicians, too, have learned from "The Star."

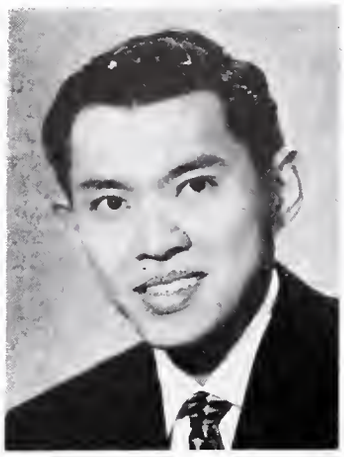
Sidney Maurice Levyson was born June 10, 1899, in Gonzales, Texas. In 1919, the first signs of leprosy appeared; diagnosis was made the following year. In 1931, he was admitted to U. S. Marine Hospital No. 66, Carville, Louisiana (now known as the National Leprosarium) and adopted the name by which he became well known, Stanley Stein. In 1937, he became blind as a result of leprous iridocyclitis. He was one of the first to receive sulfone treatment in 1941. His disease is now arrested, but he remains at Carville, working as hard as ever.

This is his story, but it is much more. It is the story of Carville, once the "Louisiana Leper Home," now the world's leading institution for the study and treatment of "Hansen's Disease." It is the story, often dramatic, of people—real people, not just "patients"—who lived, loved, worked, and died; some who succumbed, some who overcame. It is the story of the outspoken Gertrude Hornbostel and the heroic "Joey" (Josefina) Guerrero. It is the story of "the giant stride," when the sulfone drugs, promin, diasone, and others, at Carville, as in Hawaii,

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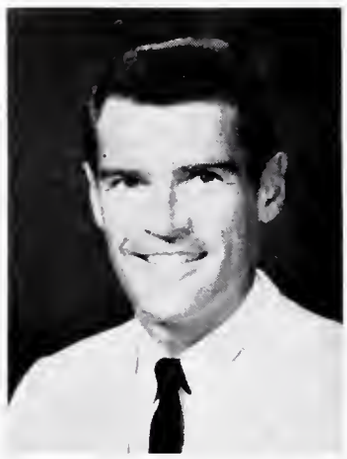
New Members



Edward L. S. Jim, M.D.

1481 S. King Street
Honolulu 14, Hawaii

General Surgery
University of Chicago, 1955
Internship—Kings County Hospital, Brooklyn, New York
Residency—St. Vincent's Hospital, New York, New York
Memorial Hospital for Cancer, New York, New York



Robert Lloyd Smith, M.D.

Orthopedic Hospital
2400 So. Flower Street,
Los Angeles 7, Calif.

Orthopedics
Yale, 333 Cedar Street,
New Haven, Conn., 1954
Internship—Veterans Administration Center, Los Angeles, Calif.
Residency—Veterans Administration Center, Los Angeles, Calif.
Orthopedic Hospital,
Los Angeles, Calif.



Gene John Ahern, M.D.

839 S. Beretania Street
Honolulu 13, Hawaii

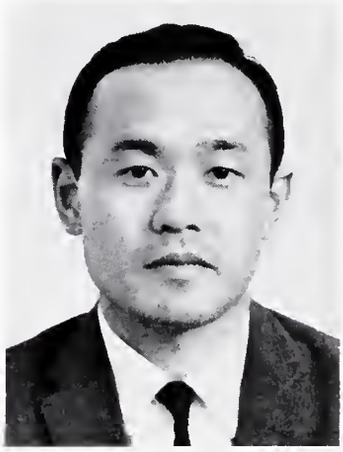
Pediatrics
University of Illinois, 1953
Internship—St. Joseph Hospital, Joliet, Illinois
Residency—University of Illinois R & E Hospital, Chicago, Illinois



Paul Kaufman, M.D.

Fleet Medical Office—CINCPACFLT
c/o FPO, San Francisco, California

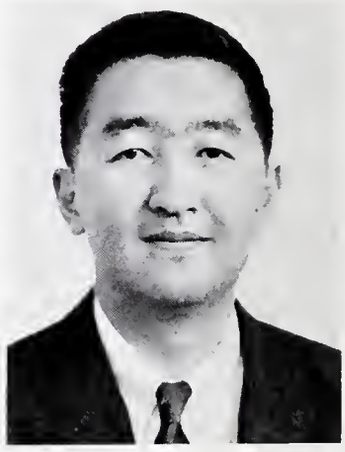
Pediatrics
The George Washington University School of Medicine, 1947
Internship—District of Columbia General Hospital, Washington, D.C.
Residency—The Children's Hospital, Washington, D.C.



Toshihiko Kawasugi, M.D.

1833 North King Street
Honolulu 14, Hawaii

Pediatrics
Hiroshima University School of Medicine, 1957
Internship—Hiroshima University School of Medicine, Hiroshima, Japan
St. Francis Hospital, Honolulu, Hawaii
Residency—Kauikeolani Children's Hospital, Honolulu, Hawaii
Baylor University Affiliated Hospital, Houston, Texas



James A. Nishi, M.D.

1833 North King Street
Honolulu 14, Hawaii

Surgery
Washington University, 1957
Internship—St. Luke's Hospital, St. Louis, Missouri
Residency—St. Luke's Hospital St. Louis, Missouri

HAWAII MEDICAL JOURNAL

County Society News



Lawrence H. Winter, M.D.
Diamond Head Health Center
550 Makapuu Avenue
Honolulu 16, Hawaii
General Practice
Stanford University, 1950
Internship—Highland Hospital,
Oakland, California

Kauai

Mr. Aubrey Gates, Director of the AMA Field Service, was the guest speaker at the September 4, 1963, meeting. Seven members were present. The Treasurer advised that the $1,500 Operation Swallow fund had been deposited in a Kauai Savings and Loan account. The HMA delegate was instructed to support Hawaii County's proposed resolution relative to election of HMA officers. Dr. Peter Kim reviewed portions of the budget to be voted on at the forthcoming interim session of the House of Delegates.

It was voted to support the Department of Health's Pregnancy Study. It was also voted to invite either one or both the Hawaii Thoracic Society's visiting doctors to address the Society's March meeting. Since there were no suggested changes to the Workmen's Compensation fee schedule, no action was taken on the communication from that office. Dr. Webster Boyden was nominated to represent the Society on the HMA's Medical Education Liaison Committee.

Mr. Aubrey Gates's talk was followed by a question-and-answer period. The meeting adjourned at 10:00 P.M.

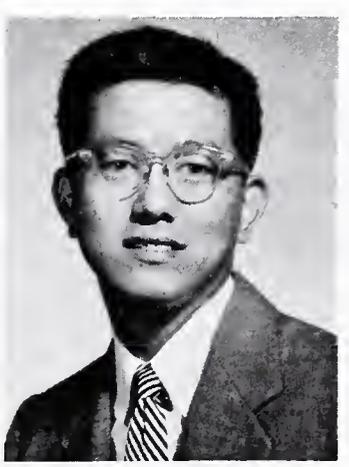
* * *

The October 1 meeting opened with a report from the Treasurer, which was followed by report from the HMA Delegate, Dr. Kim, on the Interim Session. Dr. Wade made a supplementary report. Dr. Wade also reported on the HMA fee survey and HMSA negotiations. It was voted to approve a mobile-type survey program for diabetes. Dr. Wade tentatively accepted the appointment

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Theodore K. L. Tseu, M.D.
1523 Kalakaua Avenue
Honolulu 14, Hawaii
Obstetrics-Gynecology
Yale University School of
Medicine, 1956
Internship—The Queen's Hospital,
Honolulu, Hawaii
Residency—Kapiolani Maternity
Hospital, Honolulu, Hawaii



Donald H. Ikeda, M.D.
1010 S. King Street
Honolulu 14, Hawaii
Radiology
Washington University, 1957
Internship—Jewish Hospital of
St. Louis, St. Louis, Missouri
Residency—Jewish Hospital of
St. Louis, St. Louis, Missouri

HAWAII MEDICAL JOURNAL

Notes and News

Due to the resignation of Notes & News Editor Dr. Toru Nishigaya, this section of the Journal will be discontinued until a volunteer is recruited. Members interested in taking on this assignment are asked to get in touch with Dr. Harry L. Arnold, Jr.

JOSEPH PALMA, M.D.
1896–1963

In the death of Doctor Joseph Palma on August 7, 1963, Hawaii lost a leading citizen, and the medical profession a dedicated, capable, and beloved physician.

Born in Lafayette, Indiana, on April 5, 1896, he early in his career decided to become a member of the medical profession. To this end, he enrolled at the University of Michigan in June, 1914, and was graduated in medicine six years later. His love for children and interest in their problems led him to specialize in pediatrics, three years being spent at the University of Michigan and one year at the Boston Floating Hospital. In March, 1924, Doctor Palma joined the Straub Clinic and continued as Head of the Department of Pediatrics until his death, except for active duty in the Navy during the last World War from June, 1941, to January, 1946. He was commissioned a Lieutenant Commander in the Reserve Corps in 1933, and promoted to the rank of Captain in 1945.

Doctor Palma took an active part in local and national medical affairs. He was President of the Hawaii Medical Association in 1947-1949. His activities in both the Honolulu County Medical Society and the Hawaii Medical Association were many and productive. He took a leading part in the organization and reorganization of the Hawaii Medical Service Association. Doctor Palma was Chief of Staff of the Kauikeolani Children's Hospital for many years, and at various times was Chief of Pediatrics at the Kapiolani Maternity and Gynecological Hospital. He was a member of the Plans and Policy Committee of the American Association of Medical Clinics in 1958-1960, and had been an elected member of the Board of Trustees of this Association for the three years prior to his death. He was Chairman of the Section of Pediatrics of the American Medical Association in 1961, and Chairman of the Pediatrics Executive Committee in 1962. He was certified by the American Board of Pediatrics in 1934 and took a leading part in establishing the Honolulu Pediatric Society and was its first President in 1947-1948. Doctor Palma published many scientific articles dealing with problems peculiar to infancy and early childhood, and in 1929 was the author of a book entitled "A Guide to Mothers in Hawaii." During the subsequent thirty years, it underwent nine editions.

In June, 1934, Doctor Palma married Julie Weight, daughter of an old and distinguished family of Hawaii. To this union were born a daughter, Joan, and a son, Richard, who have been a credit to themselves and to their parents. Doctor Palma was an ardent and competitive golfer and delighted in mingling with his many friends with similar interests at the Oahu Country Club over a period of 37 years. He was an active Mason, being a member of Hawaii Lodge No. 21; a Shriner; and a member of the Jesters Court No. 1. He was a member of St. Andrew's Episcopal Church.

It was a great shock to all of us, but a few weeks ago, when at exploration we found the hopeless condition for which, at present, our profession knows no cure, and which potentially carries such disabilities as to make one's remaining days a most trying ordeal. I am glad he was spared most of this by his sudden departure. I am sure all of us who knew Joe for the past many years subscribe to the fact that he was a dedicated physician in the true sense of the word; that he was honest with himself and with his patients; that he was a devoted husband and father; and that he had decided convictions that were just and honorable, and from which he did not deviate, regardless of the opinions of others, when he thought he was right. He leaves countless friends and individuals indebted to him for their well-being, their happiness, even their existence. What more can anyone hope to accomplish during one's lifetime?

J. E. Strode, M.D.

HAWAII MEDICAL JOURNAL / Hawaii Medical Association

MINUTES OF THE HOUSE OF DELEGATES INTERIM SESSION

September 7-8, 1963
Honolulu, Hawaii

The interim session of the House of Delegates was preceded by a luncheon at the Straub Clinic Conference Room given by the President, Rodney T. West, for the members of the House of Delegates, their alternates, the committee chairmen, and the AMA delegate and his alternate. After the opening remarks by the President, the AMA Delegate, Richard D. Moore, reported on the June meeting in Atlantic City.

PRESENT

The interim session was called to order at 2:30 P.M. in the Mabel Smyth Auditorium and the following were seated:

Officers: Rodney T. West, Samuel D. Allison, Herbert Y. H. Chinn, Randal A. Nishijima; *Councilors:* Bernard W. D. Fong, Chew Mung Lum, Robert M. Miyamoto, O. D. Pinkerton, Burt O. Wade; *County Presidents:* Robert P. Henderson, Theodore T. Tomita, William Iaconetti; *Hawaii Delegation:* James A. Mitchel (for Theodore T. Oto), Ruth E. Oda, Nicholas Steuermann; *Honolulu Delegation:* Grover Batten, Ralph Beddow (for O. D. Pinkerton, resigned), Robert Benson, Morton E. Berk, Charles S. Brown (for Patrick T. Lai), James W. Cherry (for Gail G. L. Li), Kenneth Chinn (for Allan Leong), William W. L. Dang, George Goto (for Frederick B. Warshauer), A. S. Hartwell, William S. Ito, Robert T. S. Jim, Carl B. Mason, Richard D. Moore, Walter M. Ozawa, Donald E. Poulson (for Unoji Goto), R. Frederick Shepard, R. Varian Sloan, A. L. Vasconcellos, Warren L. H. Wong (for Bernard W. D. Fong, resigned), Bernard J. B. Yim; *Kauai Delegation:* Peter Kim; *Maui Delegation:* Marion Hanlon, A. Y. Wong (for Edward Underwood).

MEETING TIMES

The President advised that the original notice set the Sunday meeting for 11:00 A.M. and asked if the delegations would prefer to have this session convene earlier.

ACTION:

It was voted to convene at 9:00 A.M. on September 8.

COMMITTEE REPORTS

The chair ruled that the committee reports would be given in an informal fashion and would be assigned as indicated in the agenda to discussion groups which would report back to the House Sunday morning. Except for the Bylaw changes, all reports were on budgetary requests.

Bylaws and Parliamentary Committee: Dr. Harry L. Arnold Jr. read the circulated report, which was in two parts; the first part put in proper form the changes in bylaws voted upon at the 107th Annual Meeting, the second part proposed changes voted at the 107th Annual Meeting but which had to lie over in order to conform to the sixty-day notice provisions of the Bylaws.

ACTION:

It was voted to make the following changes in the Bylaws: Chapter IX, Section 1. (e) No refund of dues or assessments may be made to members withdrawing for any reason, or to the estates of deceased members. Section 3. Delinquency. (a) A member is delinquent if his dues for any year are not received by the Association by April 1 of that year and shall automatically forfeit his membership in the Association if he fails to pay the delinquent dues within 30 days after the notice of delinquency has been mailed by the Secretary of the Association to his last known address, and to the Secretary of the county medical society to which the delinquent member belongs. The same penalties shall apply to assessments, delinquency beginning 90 days after the levying of the assessment and forfeiture of membership for nonpayment occurring automatically 30 days after the mailing of notification of delinquency to the member and to the Secretary of his county medical society. Section 4. Assessments. (a) An equal per capita assessment may be levied upon the active members of this Association (except those whose dues have been waived by a two-thirds vote of the members of the House of Delegates present and voting at any of its sessions) provided, however, that such assessment shall not exceed $25 per member per twelve-month-period without referendum. (b) Assessments shall be prorated for new members on a quarterly basis. Chapter X, Section 1. (a) The fiscal year of the Association shall be July 1 through June 30 of each year. (b) The dues year shall be the calendar year.

Maternal and Perinatal Mortality Study Committee: Dr. George Goto explained the work of this committee, particularly as it relates to the neighbor islands. He advised that the Department of Health subsidizes the neighbor island trips of two members; other members of the committee have been paying for their own transportation and lodging when the committee meets on the neighbor islands. He read a letter which he had sent to the President when he made his original request for funds to cover travel expenses and outlined how the $300 would be spent if it were included in the budget. He was asked if he thought $300 was sufficient and answered that he believed this amount would permit them to operate at an acceptable level. Dr. Goto told the House of the new law which was passed at the last legislative session that protects the confidentiality of the investigative committees. He also made recommendations for individual hospital perinatal mortality study committees.

Careers: Dr. John Stephenson appeared for the committee chairman and said the amount requested is to cover a second careers day program plus a health futurama project, with which he was not familiar.

Medical Care Plans and Fees Committee: Dr. George Mills reported on the present status of the fee study and advised that at the present time it would appear that the total amount requested may not be needed, but since there is no precedent upon which to base an estimate of costs, asked that the amount requested be allotted. He advised that he had recently taken over the chairmanship of the committee and the request for funds to cover meals was entered because of the exceptionally long hours this committee met, starting at four in the afternoon and running through sometimes until midnight.

Mental Health: Dr. George Schnack gave the House some background information on the mental health programs in Hawaii. He advised that in the past money had been received from other sources to cover transportation of Hawaii representatives to mainland meetings. It does

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: JAMES YANO, Kaiser Foundation Hospital

1963-64 Officers Of Hawaii Society Of Medical Technologists

We are proud to present the officers, board members, and standing and special committee chairmen of the Hawaii Society of Medical Technologists for 1963-64. To direct and coordinate the activities of this organization the members have elected Jack Furuta as president.



New officers. Left: Mr. Jack H. Furuta, President of HSMT. 1963-64; Mr. Kenneth Sato, President-elect.

Mr. Furuta was born, raised, and educated in the scenic town of Laupahoehoe, located on the beautiful Hamakua coastline on the Island of Hawaii. He graduated from the University of Hawaii in 1958 with a B.S. degree in medical technology. Since then, he has worked at St. Francis Hospital laboratory and subsequently at the Queen's Hospital. Always active in all affairs of the organization, he has been chairman of numerous committees of the HSMT. He has also been active in the Young Buddhist Association, serving in the capacity of corresponding secretary and administrative vice-president of their Toastmasters' Club.

Mr. Kenneth Sato of Honolulu, the president-elect of HSMT, also received his B. S. degree in medical technology from the University of Hawaii in 1958. After completion of his internship at Tripler General Hospital, he was a member of the laboratory staff at Kaiser Foundation Hospital for several years before going to work with the Pathologists' Medical and Cytology Laboratory. He, too, has been very active in the organization, especially as our competent treasurer last year.

Other officers for the forthcoming year are as follows: Lillian Tanaka, recording secretary; Frances Koike, corresponding secretary; Kaname Saito, treasurer; Elizabeth Hughes, Rachel West, and Flossie Kamikawa, members of the board of directors.

The following members were appointed to serve as chairmen of the respective standing and special committees: Louise Wulff, constitution and bylaws; Phyllis Sonoda, convention; Elizabeth Hughes, education; Clara Nagano, finance; Leslie Nakashima, membership; Dorothy Matsuo, nominations and elections; Kenneth Sato, program; James Yano, publications and public relations; Alice Tonchen, recruitment; Masaji Nakagawa, scholarship; Lorene Leong, standards and studies; Ann Stegmaier, research and placement; and Ronald Miyakawa, civil defense.

Who's Who

Mrs. Alice Tonchen, Chief Medical Technologist at St. Francis Hospital, received her B. S. degree in chemistry from the University of Hawaii. After completing her internship in medical technology at Mt. Sinai Hospital in Cleveland, Ohio, she worked as a chemist with the Thomas Edison Company in New Jersey for four years. After returning to Honolulu, Mrs. Tonchen was employed at Straub Clinic, Children's Hospital, and is presently at St. Francis Hospital. She is one of the past presidents of the HSMT, is recruitment chairman for this year, and is also a member of the Hawaii Society of Nuclear Medicine. Her son is a scholarship student at Punahou School.

Other members of the laboratory staff at St. Francis Hospital, directed by Dr. Paul Tamura, pathologist, are as follows: Zora Enomoto, Flossie Kamikawa, Dorothy Kodama, Barbara Sheaffer, Joyce Mizokawa, Max Bowman, Lavonne Kopp-



Chief Medical Technologists of four Honolulu hospitals. Seated, left to right: Mrs. Alice Tonchen, St. Francis Hospital; Mrs. Lorene Leong, Queen's Hospital. Standing, left to right: Mr. James Yano, Kaiser Foundation Hospital; Mr. Steve Chinen, Kuakini Hospital.

man, Dianne Retzloff, Phyllis Morita, Judith Harada, Christine Chew, Cynthia Lee, Henry Kiyabu, David Chun, Delfin Adlawan, and Richard Miyaji. Student interns in medical technology are Beverly Johnson, Diane Ogasawara, and Raymond Tomei.

The Chief Medical Technologist at Queen's Hospital is Mrs. Lorene Leong. She received her B. S. degree in medical technology from the University of Hawaii after serving her internship at Queen's Hospital. After working at Queen's Hospital for four years, she left for Letterman Army Hospital in San Francisco for about a year before returning to Honolulu to rejoin the staff at Queen's Hospital laboratory. Mrs. Leong has been Chief Medical Technologist since October of 1960. During that same year, she was elected president of the HSMT and presently, she is the chairman of the standards and studies committee. She has three active sons at home. Dr. Harold Civin, pathologist, is the Director of Laboratories at The Queen's Hospital. Other medical technologists on their staff are Phyllis Sonoda, assistant chief medical technologist, Hisashi Araki, Evelyn Chinen, Emily Czajkowski, Delle Bredesen, Laverne Bear, Jack Furuta, Beatrice Herrera, Edward Higuchi, Florence Hayakawa, Barbara Ishimoto, Barbara Larkin, Juan Macanas, Roy Mashiba, Ellen Okamura, Mary O'Connor, Gail Oyama, Ronald Okada, Edna Roelofs, Barbara Sasaki, Ella Sakai, Kathryn Scott, Elaine Tsuneda, Annette Wills, Irene Wakatsuki, Lorena Wong, Elaine Witcher, and Hiromi Wasai. Marilyn Young, Jean Shiota, Charlotte Hiroe, and Patricia Kiyabu are the students interning at Queen's Hospital from the University of Hawaii.

Mr. James Yano, Chief Medical Technologist at Kaiser Foundation Hospital, studied at Boston College during his freshman year, returned to Honolulu due to the death of his mother, and therefore completed his education for a B. S. degree in medical technology at the University of Hawaii in 1953. For five years, he was laboratory supervisor at St. Joseph's Hospital in Alton, Illinois, before returning to Honolulu to set up the laboratory facilities at Kaiser Foundation Hospital in September, 1958. Mr. Yano is presently the chairman of the publication and public relations committee of the HSMT. He was the past president of the employees' organization at that hospital. He is blessed with a son and a daughter. The Director of Laboratories at Kaiser Hospital is Dr. James G. Bennett. Other members of their laboratory staff are as follows: Mabel Nakamura, Mary Nakamura, Webster Tom, Bessie Donahue, Margit Lindblad, Simonne Massicotte, Margaret Thom, Clarence Yoshino, Marian Heidel, Alfonso Faustino, Larry Broel, Janet Morey, Marcia Connors, Bonita Wagner, and Esther Ching. They have Charles Ichioka and Paul Nakama as student interns.

Kuakini Hospital's Chief Medical Technologist is Mr. Steve Chinen. With the completion of his training at Queen's Hospital, he passed the ASCP Registry Examination in 1930 to become one of the first registered medical technologists in Hawaii under the American Society of Clinical Pathologists, with a registry number of 391. Since then he has been the Chief Technologist at Kuakini Hospital laboratory. The pathologist and Director of Laboratories at Kuakini Hospital is Dr. Grant Stemmermann. Their staff members include: Gladys Ishida, Betty Kurisu, Thomas Sodetani, William Lau, Patricia Cho, Joyce Watanabe, Joyce Inomoto, Patricia Kamiya, Florence Kamiya, Daniel Hori, Margaret Suenaga, Paul Nishida, Patsy Matsunaga, Koji Nomura, Edmo Cayaban, and Hajime Imada. From the University of Hawaii interning there are Kay Sonomura and Priscilla Taba.

Letter From Afghanistan

The editor has received a letter from the courageous medical technologist, Miss Carolyn McCue, who has spent almost two years in Kabul, Afghanistan, setting up a modern laboratory as well as teaching the natives techniques and procedures in clinical laboratory practice:

"Dear Editor: On my return home from Afghanistan where I have spent the past 22 months, I learned that members of the HSMT had collected and sent to me in Kabul, a box of lab supplies and equipment for use at Avicena Hospital. I am very sorry to report that the box never arrived. I was unaware that one had been sent and would like to offer a belated thanks to all of you for your efforts.

"During my first six months in Kabul, I was desperately short of supplies; you name it, I didn't have it. But now the laboratory at Avicena is pretty well equipped. I have enclosed a few pictures showing the general lay-out of our laboratory and the Afghan technicians with whom I worked.

"I am very happy to have been accepted for another tour with MEDICO; this time in Kuala Lipis, Malaysia, where I report for duty on October 6th."

Important Memo To Members From ASMT

"When word went out last spring that ASMT was facing a costly series of lawsuits brought by the Carnegie College of Cleveland, many of you came through in fine style, with letters of encouragement—and substantial contributions to ASMT's legal defense fund.

"These contributions totaled some $9,900.00 from individuals and around $3,700.00 from state and local societies.

"While this seems like a lot, it isn't going to be half enough. ASMT will have to plan on substantially more as its share of the whole legal defense. Although all other suits have been closed, the NCCMT suit is still in progress. Too, this $9,900.00 from individuals represents only $1.00 per member—and we know you can do better than that!

"Support ASMT against legal attack. Write check (tax deductible) now! How about $10.00? Payable to: ASMT Legal Defense Fund, c/o Miss Thelma Woods, MT(ASCP), 819 Centinela Avenue, Santa Monica, California."

Placement Bureau Approved

The executive board of the HSMT has approved the installation of a placement bureau for medical technologists here in Hawaii. All inquiries as to the availability of and possible placements for vacancies existing in Hawaii should be directed to the chairman, Anne Stegmaier, at the Blood Bank of Hawaii, Honolulu.



MEDICAL PLACEMENT BUREAU
and
NURSES' REGISTRY

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Nurses, Supervisors
Practical Nurses
Nurses, Aide
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Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*
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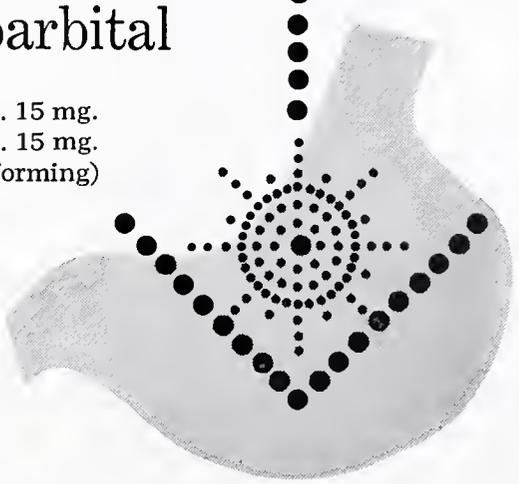
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Book Reviews *continued from 125*

changed hopelessness to hope. And it is the story of how Federal bureaucracy came at length to see the nation's responsibility.

But above and beyond this, it is the tale of a devoted band of patients who, with Stanley Stein as their leader, first through "The 66 Star," then by its successor, "The Star," now in its 21st year, have striven to carry their message to the world. We may, and do, disagree with their emphasis on the term "Hansen's Disease"; but we heartily agree with spreading the word that sick people should not be called "lepers"; that leprosy today is not the "leprosy" of the Bible; that it is only slightly communicable; that there should be no stigma attached to it; and above all that it is curable, and ex-patients should be accepted and encouraged to take their place in the community.

While this book is not a medical text, errors are surprisingly few, and this mostly in areas where the authors do not have direct knowledge. Page 45: "Amyloidosis is a leading cause of death at Carville, but as far as I know, at no other leprosarium." Amyloid, especially in the kidney, has caused numerous deaths at Kalaupapa, and still may do so for patients whose active lepromatous disease has been arrested 10 years or more. Page 323: "Therapy for syphilis is poison to a Hansenite." *Was*, not *is;* especially KI. But penicillin is acceptable. Page 325: "In 1962, the only leprosarium in American Samoa was closed and the last few patients transferred to a general hospital." A Honolulu physician, recently in Samoa, reports that this is incorrect.

Just how much of the credit for improvements, at Carville and elsewhere, belongs to Stanley Stein and his fellow-workers, may never be known. But there is no doubt that their influence was, and continues to be, real and vital.

Doctors, if you are interested in truth which reads like fiction; in getting the patient's viewpoint on a great institution, and on a disease still too prevalent here in Hawaii; and perhaps in getting a few new pointers for yourself—read this book!

NORMAN R. SLOAN, M.D.

★A Textbook of Neurology, 3d Ed.

By H. Houston Merritt, M.D., 803 pp., $12.50, Lea & Febiger, 1963.

THIS IS the third edition of H. Houston Merritt's textbook of neurology which has always been popular with medical students and general physicians because of its easy readability and excellent, though brief, coverage of the field of neurology. The third edition maintains these features, and several new syndromes and diseases which were not included in the second edition (1959) are added. In addition, the chapter on cerebral vascular diseases has been revised in the light of the more recent work and emphasis on the major vessels of the neck.

For its purposes, Dr. Merritt's textbook remains an excellent one. It is one of the texts that I usually recommend to interns and medical residents who have not had much exposure to neurology.

MICHAEL M. OKIHIRO, M.D.

Counseling in Medical Genetics, 2d Ed.

By Sheldon C. Reed, Ph.D., 278 pp., $5.50, W. B. Saunders Company, 1963.

THE DISTINGUISHED director of the Dight Institute for Human Genetics at the University of Minnesota has provided, in this second edition of his book, a useful account of his long experience in genetic counseling. Inasmuch as one child in fifty presents some serious physical or men-

continued page 152

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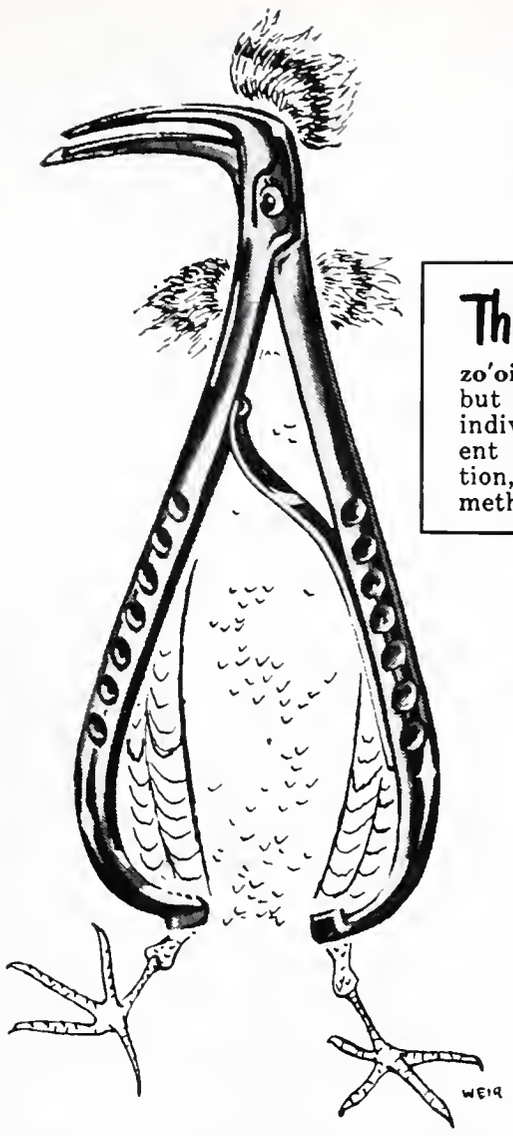
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County Society News *continued from 127*

to the HMA Federal Medical Service Committee. Drs. Goodhue and Miyashiro were appointed to the Department of Health's County Steering Committee on Mental Health. The Society agreed to contact the Superintendent of Public Instruction to seek his approval for placing the AMA health posters in the three high schools with the idea of offering prizes for copies that could be placed in public places. It was voted to purchase three copies of "Admission Requirements to Medical Schools" and place them in the high school libraries. It was voted to accept Mr. Veltmann's offer to send a HMSA representative to Kauai every three or four months to answer questions. The meeting concluded with a talk by Dr. Ivy on the various programs being developed by the HMA.

Honolulu

Approximately 233 members attended the September 3 meeting. The following new members were welcomed into the Society: Drs. Gene John Ahern, Clarence Melville Baugh, Robert Eugene Boyd, Walter F. Char, Hugh Lloyd Davis, Jr., Daniel Dooley Palmer, Theodore K. L. Tseu, and Paul Kaufman, who was not present. Resolutions were adopted in memory of Drs. C. W. Trexler, Harold McKeen, Jr., Joseph Palma, and Donald Wright. The new Executive Secretary, Mr. H. Tom Thorson, was introduced to the members.

After a short talk by Aubrey Gates of the AMA and papers by Drs. William H. Stevens and Walter Chang, the following announcements were made: Dr. Fred Lam, Jr., announced the new radio call service available through the Physicians' Exchange. The Chair advised that Dr. B. Allan Richardson had been appointed to the Advisory Council of the Congenital Defects Center and Dr. Bernard Yim was named Consultant and Advisor to the Kapiolani Technical School Practical Nursing Department. Dr. John Lowrey announced that negotiations were beginning with Mabel Smyth relative to the excavation of the basement and advised that temporary quarters for the BME will be made available in the former library quarters. The Chair also announced that a 19-man steering committee has been named, in accordance with the Michael-Uhl report, and that the problem with the Philippine Counsul General had been resolved and a review panel would be established. Dr. Tomita announced that the change in paragraph 5 of the HMSA participating physician's agreement was made at the request of the Society to provide referral of disciplinary actions to the component societies. Also that it is recommended that physicians not bill for care given under their general direction unless they are present. Dr. George Mills advised that the fee schedule survey is progressing on schedule.

The lengthy discussion on the appointment of an assistant medical director for HMSA included a statement from the podium by Dr. Toru Nishigaya. Final action was taken when a motion was passed to refer the question to the Nominating Committee for the nomination of five physicians to be voted on at the next meeting of the Society. The motion called for the inclusion of Dr. Nishigaya's name but he requested that it not be included. ■

Hawaii Medical Association *continued from 129*

not look as though it will be possible to secure funds to send anyone to the March 1964 meeting in Chicago and requested $500 to cover travel costs with the per diem expenses to be taken out of whatever surplus develops when the final accounts of the Mental Health Conference are known. The $200 allocation was not used.

Public Relations Committee: Dr. Andrew C. Ivy, Jr., reviewed the PR programs now being directed by his committee. Dr. Steuermann pointed out that the amount requested represents one-fifth of the budget. He challenged the statement that the PR program had raised the image of the doctors. He told of the activities on the Big Island and questioned the necessity in this State of combatting socialized medicine which might or might not come. He felt more money should be spent for committees such as mental health, diabetes, etc., and that the doctors should improve their own image. Dr. Ivy entered a plea for the House to reinstate the amount the Council recommended deleted from the Message of the Month allocation and explained that part of this money will have to be diverted to the Kerr-Mills flyer which was originally estimated to cost about $400 and now that it is in final form it is found that it will run around $1,000.

Legislative Committee: Dr. John Chalmers advised that the Council's recommended cuts in the committee's budget would not hamper its operation. However, he recommended that the proposal that Mr. Honda be put on a year-round retainer at $200 a month be approved. In addition Mr. Honda would be paid a fee of $1,600 for budget sessions and $4,600 for general sessions. Dr. Liljestrand spoke on the activities of the Political Action Committee and asked for recommendations to make it more effective. Dr. Moore asked if the increase in the total fee were granted, if there would be any additional fees for extended sessions. It was agreed to make certain that no additional fees would be applicable regardless of the length of session. The importance of the annual dinner for legislators was questioned. The advantages of small dinners, especially on the neighbor islands, were pointed out. Dr. West spoke of the influence of the neighbor island doctors and their legislators.

Executive Offices: Dr. West explained the need for increased staff and space which was pointed to in a recent investigation. Dr. Tomita felt the delegates should be informed of these findings. Dr. West said the findings were that the Association should have an executive secretary who would have proper assistance to carry on the work of the Association and that she should also have more control over the public relations counsel and some direct connection with the legislative counsel. Also that money should be appropriated to make changes in the administration. There should be one assistant and another secretary.

DISCUSSION GROUPS

The President advised that discussion group leaders had been chosen from the elected councilors and asked that they confer with the Treasurer and be prepared to report back the next morning. The following assignments were made:

Group Leader: Bernard W. D. Fong; *Members:* James A. Mitchel, Grover H. Batten, Charles S. Brown, Bernard J. B. Yim; *Topics:* Journal, Audit and Accounts, Auto Expense, Postage, Rent, Repairs, Salaries, Taxes, Investigation.

Group Leader: William E. Iaconetti; *Members:* Robert Benson, William Dang, Richard Moore, Warren Wong, Ralph Beddow; *Topics:* Annual Meeting, Post AMA Meeting, Interest, AMA Convention, Postconvention.

Group Leader: O. D. Pinkerton; *Members:* Ruth Oda, William Ito, Robert Jim, Peter Kim, Marion Hanlon; *Topics:* Careers, Diabetes, Public Relations, Mental Health.

Group Leader: Robert Miyamoto; *Members:* Kenneth Chinn, James W. Cherry, R. V. Sloan, R. F. Shepard; *Topics:* Hawaiian Academy of Science, Council, Donations, Library, Legislative, Maternal and Perinatal Mortality Study.

Group Leader: Chew Mung Lum; *Members:* A. L. Vasconcellos, Walter Ozawa, Morton Berk, Carl Mason, A. Y. Wong; *Topics:* Reserve Funds (Entertainment, Moving, Miscellaneous, President's Contingency, Furniture & Fixtures, Retirement), Stationery (Printing & Supplies), Telephone, Medical Care Plans & Fees.

Group Leader: Burt O. Wade; *Members:* Nicholas Steuermann, George Goto, Donald Poulson, A. S. Hartwell; *Topics:* Woman's Auxiliary, Travel, Miscellaneous Income, Interest Income, Legislative Assessment, Deficit Spending.

continued page 140

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Hawaii Medical Association *continued from 138*

FINANCE

Mr. Melvyn Leong of the firm of Leong and Leong filed the auditor's report for the six-month period ending June 30, 1963. He read pertinent parts of the report and asked if there were any questions. The Treasurer referred his report which had been circulated and advised that he would circulate among the discussion groups to answer questions that might arise.

* * *

The interim session reconvened at 9:00 A.M. September 8, 1963. The Secretary called the roll. No additional alternate delegates were seated in place of absentees.

MR. AUBREY GATES

The President asked the Director of the AMA Field Services Department to address the House. Mr. Aubrey Gates said that after having visited each island and seen each Society in operation, more or less, he had a much better understanding of the affairs of this State, although he would not attempt to be a 10-day expert. The people here have the same problems and opportunities that people everywhere share. Before his visit everything was nebulous, he only had a book knowledge. He wondered if some of the doctors in Hawaii had the same feeling about the AMA. He expressed the hope that his trip had contributed a little to a better understanding. He spoke of the role of the AMA's Legal Department and their research work. He had been asked why the AMA doesn't poll the entire membership on controversial subjects, especially on Social Security coverage. The AMA cannot; it would be unconstitutional. If they could, it would not be wise. The U.S. Congress is not run that way. Representatives are elected and ours is a representative form of government. We follow a democratic process. When the AMA delegates meet, it becomes the responsibility of the Legal Department to determine what is legal.

Mr. Gates said he had not seen a detailed budget study done in any other medical association. The AMA budget is published in the AMA handbook. He called attention to some of the figures. The AMA salaries come from dues; the rest of the services are paid out of other income items in the budget. The $20 increase was to pay for the services of the physicians who contribute their time to the AMA work.

The Public Relations Committee work was complimented. Mr. Gates said this was not his primary responsibility as it comes under the AMA's Communications Division, but public relations is everybody's business. This cannot be exclusive. Medicine is fighting a battle against socialized medicine in a climate created by what people think. They are having their opinions molded by the currents, cross-currents, etc. Then they make their judgment. The "judgment of the people can be no better than its information."

Mr. Gates said he was impressed by the Message of the Month project. It is a new concept and he is taking it back. This is an excellent thing that is being done over the year. He was also favorably impressed with the TV and radio productions and the press relations.

Public relations starts in the doctor's office. There is no substitute for it but it doesn't end there. He cited the attacks that have been made on organized medicine. Many of the opponents of medicine have ceased to discuss the facts and are attacking the AMA. They are following the axiom that when you can't try the cases on facts, try the other lawyer. We have to develop a climate where these distortions cannot take place. He referred to the often heard statement that the AMA is against everything. If you are for pretty flowers, you are

continued page 142



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Esters	0.03%	0.01-0.13%
Aldehydes	trace	trace-0.03%
Formaldehyde	absent	absent
Furfural	absent	trace-0.01%
Alkaloids	absent	absent
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Hawaii Medical Association *continued from 140*

against insects and disease. Seven of the ten commandments say "thou shalt not." The AMA has the responsibility of speaking out against things that are not in the best interests of the practice of good medicine.

Operation Hometown is the most important thing the doctors will be doing now and the next few months. He urged the Association to develop a full-blown program as quickly as possible and to get the public to fully understand this issue. Mr. John Pompelli, field representative of the AMA, will be assigned to visit this state. Mr. Gates thanked the Association for the opportunity to speak at its meetings and for the hospitality that had been extended to him.

INTRODUCTION OF RESOLUTIONS

The President advised that resolutions would be introduced, but that there would be no need for action. Dr. Steuermann introduced the following resolution entered by the Hawaii delegation:

RE: ELECTION OF OFFICERS BY THE HOUSE OF DELEGATES

WHEREAS, The elected officials of the Hawaii Medical Association are responsible for the well being of this Association; and

WHEREAS, The affairs of the Hawaii Medical Association, are of increasing importance to the profession and to the community; and

WHEREAS, It is desirable that the membership of the Association have sufficient time to examine the qualifications of candidates for election; therefore be it

Resolved, that this House of Delegates instruct the Bylaws and Parliamentary Committee to present to the 108th Annual Meeting of the Hawaii Medical Association a revision of the current bylaws which would provide that the Nominating Committee's Report be circulated to the membership within thirty days after it has been completed and that further nominations for election by the House of Delegates can be made only by petition of fifteen or more members in good standing, provided the petition is presented to the constituent Secretary within thirty days after the Nominating Committee's Report has been circulated to the membership or within sixty days of the annual meeting at which the election is to take place, whichever is later, and thereafter there shall be no further nominations for election except in the case where there is only one nominee for a vacancy and that nominee has withdrawn; and be it further

Resolved, that the entering of this resolution upon the minutes of the September 7-8, 1963, meeting of the House of Delegates shall serve as notice, as provided in the Bylaws, that a change in the method of electing officials of the Hawaii Medical Association may be voted on at the 108th Annual Meeting without further notice to the membership or the component societies.

The Chair ruled that the Hawaii resolution be referred to the Bylaws and Parliamentary Committee with instructions to report back at the next meeting.

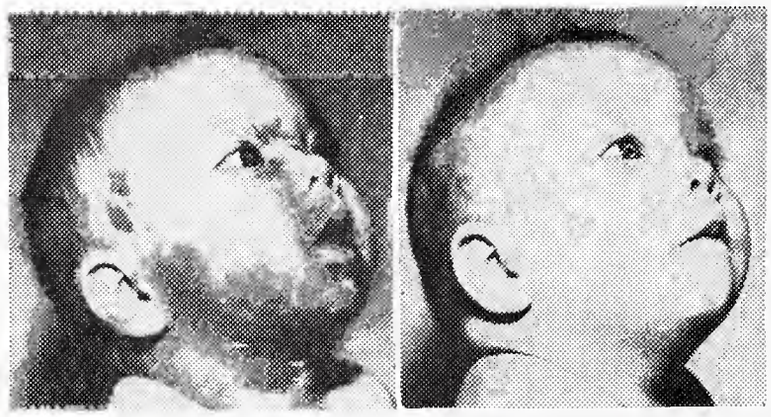
DISCUSSION GROUP REPORTS

The President asked the discussion group leaders to make individual reports in an informal manner and advised that the reference committee format would not be followed at this session.

Bernard W. D. Fong reported that his group recommends approval of all portions of the budget assigned to him. He noted that additional expenses for rent and moving cannot be predicted because there is no definite date for moving into larger quarters although there was

continued page 144

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Reports & Snorts

A cloek in motion relative to the surfaee of the earth actually runs slower—not enough slower to be notieed unless the motion is extremely fast, however. If it moved almost as fast as light (a speed whieh would require expenditures of power impossible today) the difference would be fantastie: at a speed 0.9999 times that of light, the eloek would take an hour of earth time to advanee one minute! If you were to take a one-year round trip at sueh a speed, you would be one year older on your return and your friends at home would be sixty years older, or dead. A five-year trip would bring you home in the year 2263! Travel into the past is impossible, but travel into the future is merely expensive; there is nothing fundamentally impossible about it. One trouble: you'd have to stay there. But what a eontribution to the historians of the future!

• • •

The protons (hydrogen ions to you) making up the "solar breeze" stream outward from the sun at velocities ranging from 300 to 600 kilometers per second, and their impact pressure is equivalent to a surface wind moving about 0.01 cm. per second. But each particle in this "breeze" has about 31,000 times the energy of each ordinary air molecule.

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If you disapprove of fluoridation, how about coming up with a suggested alternative to it? You must admit we have a serious problem on our hands, and that what we have been doing about it these past two or three decades has been virtually a complete failure. What else can we try?

• • •

If you told an English guest you were going to have him sleep on the davenport he would probably think you had lost your mind. To an Englishman, a davenport means a writing desk with a hinged writing surface: what an Ameriean would eall a seeretary, or a Frenchman an *escritoire*,— the word, no doubt, from whieh "seeretary" in this sense was derived.

• • •

***Current Medical Terminology* is a pretty wonderful paperback, incidentally. It lists alphabetically 2,709 diseases by their preferred names (837 more than last year's edition). For nearly every one, it lists the following: additional terms, or synonyms; etiology; symptom(s); signs; complications; laboratory data; x-rays; and pathology. A 16-page numerical index and a 95-page concordance index (with headings, in alphabetical order, like "abdominal," "edema," "atrophy," "infantile," and so on) complete this excellent volume—and all in coat-pocket size!**

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The tobaeeo company PR man had just run across a ehap who smoked eight paeks of eigarettes a day, and was understandably exeited and pleased. "Will you appear on our TV program?" he asked. "We'll pay you $10,000." "Glad to," replied the man. "All right, be down at our studio tomorrow at 9:30, then." "Oh," said the fellow; "I eouldn't do that." "Why on earth not?" asked the PR man. "Well, you see," said the man, "I ean't stop eoughing before noon."

• • •

Don't miss Alone No Longer, *the dramatic life story of Stanley Stein, founder and editor of the Carville leprosarium* Star, *reviewed in this issue of the* JOURNAL.

And don't overlook the manifold delights and belly laughs in Alexander King's Mine Enemy Grows Older *and* May This House Be Safe From Tigers, *both published in a pocket book edition.*

• • •

Between 1950 and 1962, the U.S.A. slipped from sixth lowest in infant mortality to eleventh, among 15 countries. Top three in percent decrease since 1950: Finland (15.9%, now in fourth place); Japan (52.4%, now fourteenth); Ireland (47.6%, now tenth).

• • •

If you were in an elevator on your way to a jam session, to be held on the second floor of the Young Hotel, carrying your cornet with you, and an elderly Hawaiian lady carrying a trumpet asked to be let off on the second floor, you might well say to her, "Oh, are you going to two to toot too, tutu?"

• • •

Krugman, Giles, Jacobs and Friedman of NYU reported recently that Schwarz's "further-attenuated" measles virus vaccine without gamma globulin gave about the same proportion of reactions (15%) as Edmonston "B" vaccine with gamma globulin. The new vaccine may be commercially available early next year through Pitman-Moore.

a division of opinion. His group recommended approval of the request for two more full-time employees. There was general agreement that additional personnel is necessary to run the office efficiently and make the committee chairmen's work less burdensome. The one member that opposed the suggested increase in staff did so on the basis that it might be better to increase the clerical staff, rather than the administrative. Dr. Hartwell asked for an explanation of the work of the administrative assistant. He was told of the time involved in carrying out the administrative duties and that the Executive Secretary is currently working 60 to 80 hours a week. An assistant would be delegated to take day-to-day running of the office and help with the committee work. He was advised that the Executive Secretary will write up a job description and submit it to a subcommittee of the ad hoc committee. The appropriate committee of the Council should then decide which person should be hired first and if the 4th person should be added. After the studies have been completed and the committee has discussed the job descriptions, the proper person would be hired to fit the spot, whether it be assistant or stenographer. Dr. Fong said that it is not the intent of the discussion group to recommend that both positions be filled immediately. The question was raised if the Executive Secretary knew what she wanted. Dr. Fong explained that this was in line with her request.

Dr. Fong explained that the increased budget for taxes was based on higher rates of pay and increased personnel. The Investigation Committee's allocation of $500 covers the cost of the study of running the executive offices. Originally part of this money was taken out of the President's Contingency Fund by Dr. Giles.

ACTION:

It was voted to approve this portion of the budget without change as recommended.

William E. Iaconetti reported that his group recommended approval of the portion of the budget as submitted with the exception of the AMA expenses. They recommended that instead of the $1,420 proposed for a hospitality room at the San Francisco AMA meeting, $700 be set aside for this purpose to be used at the discretion of the AMA delegate. His group felt that this is a definite need on the part of the Association since our officers and delegates have for many years accepted the courtesies extended to them by other associations and it was due time that the HMA came of age. The reduced amount was discussed with Dr. Moore who advised that this amount should cover the requirements if the room is not open every day of the meeting.

ACTION:

It was voted to approve of this portion of the budget as recommended with one change; the total amount alloeated for the AMA meeting expenses is changed to $2,910.

O. D. Pinkerton reported that his group recommended approval of the portion of the budget they studied with the following changes: The Diabetes Committee allocation be deleted and this activity put on a county level and financed by the individual counties under the direction of the State; that the Careers Committee allocation be reduced to $370 as recommended by the Council and that this committee be instructed to conduct its activities on a statewide basis; that the portion of the Public Relations Committee allocation covering the Message of the Month expense be reduced to $2,100 and that for the Miscellaneous Flyers be increased to $1,000. Dr. Pinkerton said he had been advised that Dr. Schnack had requested $500 to cover the expense of sending a representative to Chicago in March. Although he was not aware of the request, the group felt this was the intent of Dr. Schnack's presentation and recommended that this amount be included.

Dr. Berk commented on the proposed deletion of the budget item for the Diabetes Committee. He pointed out that the Honolulu County Society practically refused to put money out for this program. He thought it was one of the best means that we have of positive public relations. He asked if the neighbor islands had ever requested money and been refused. The answer was no. Dr. Pinkerton said that it was agreed that the program should continue to function. The objection to the allocation was that the money has all been spent in Honolulu and it has been the only county to benefit. Dr. Hanlon suggested that the budget be increased to cover supplies for the neighbor islands.

Dr. Pinkerton said that the benefits to the neighbor islands had been discussed as they related to the Careers Committee activities. The group felt they should accept the recommendations of the Council. In addition they suggest that the neighbor islands submit their expenses to the State for payment. The groups realized that this is a loose arrangement but it was felt that these expenses would not be very large. Dr. Berk spoke against the payment of meals and stated that no participating doctor would object to paying for the students in his group.

Dr. Leo Bernstein was present at the meeting and he was asked if the Department of Health planned to send someone to the Mental Health Conference in March. He said this item was not budgeted.

Dr. Pinkerton explained the group's recommendations to cut the Message of the Month allocations and increase the Miscellaneous Flyers allocation. The group did not disapprove of the concept of the Message of the Month; their recommendation was entered with the intent of keeping the budget as low as possible. Dr. Ivy was asked to comment on this recommendation. He explained that every effort was being made to get outside funds for the Message of the Month project and this had been accomplished. The Miscellaneous Flyer budget was found to be much too low and the committee expected to use some of the Message of the Month funds to make up the difference. Dr. Steuermann spoke against the allocations for printing a Kerr-Mills flyer. He didn't think the doctors gave the people as much free advice as we would in the Message of the Month. The question arose whether the reverse side of the Message could be used for a paid message from other groups such as the pharmacists. Dr. Hanlon spoke against the cut and proposed a vote of confidence to Dr. Ivy and his committee. Dr. Yim expressed his reservations about the Message of the Month project and Dr. Brown said he used the flyers for scratch pads. Dr. Ito said he recommended the cut as a means of economy. If the Association had ample resources, he would have recommended a great deal more. A lengthy discussion followed on the implementation and value of the program.

At the conclusion of the discussion Dr. Pinkerton recommended that each committee chairman be required to attend House of Delegates' budget meetings or send an alternate.

ACTION:

It was voted to approve the Diabetes Committee's alloeation as requested.

It was voted to instruet the Diabetes Committee to extend its program to the neighbor islands.

It was voted to follow the Couneil's recommention and reduee the Careers Committee's request to $370.

It was voted to alloeate $500 to the Mental Health Committee to eover attendanee at the AMA meeting in Mareh with the provision that the representative be a member of the HMA who is ehosen by the Mental Health Committee.

It was voted to allow the Publie Relations Committee the full amount requested.

Robert M. Miyamoto reported that his group recommended that the portion studied by them be approved as requested except that the Legislative Committee's allocation be expanded to include a retainer fee of $200

continued page 146

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References: (1) Ravetz, E.: Current Therap. Res. *5*:75-80 (Feb.) 1963. (2) Morrison, B. O., and Bernheim, E.: accepted for publication: J. Am. Geriatrics Soc. (3) Current Concepts in Therapy: New England J. Med. *255*:706 (Oct. 11) 1956. (4) Goodman, L. S., and Gilman, A.: Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1956, pp. 163-166.

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a month for the Legislative Counsel beginning October 1 plus $1,600 for the budget session. It also recommended that the $1,400 collected by the assessment in the last fiscal period be made available to this committee. Dr. Berk said this money could not be transferred to the General Fund; it has to stay with the Legislative Committee. He recommended deletion of the $500 for the extended session and the inclusion of a stipulation that the Counsel will not charge extra for an extended session. Dr. Tomita asked if there was a provision in the contract that the fee requested would be the total fee. Dr. Chalmers advised that was his interpretation and this will be clarified before the contract is signed.

ACTION:

It was voted to approve this portion of the budget as set forth with the exception of the budget for the Legislative Committee which shall have the Counsel's fee increased to include $1,600 for the budget session and $200 a month for a retainer fee effective October 1, 1963.

It was voted to eliminate the extended session allocation and to follow the Council's recommendations on the entertainment and miscellaneous expenditure items; that is, to combine the $750 for the dinner and the $1,500 for entertainment item and reduce this figure to $1,000, and to combine the $500 miscellaneous allocation and the unassigned $30 and reduce these items to a total of $250.

Chew Mung Lum reported that his group recommended deletion of the $300 from the Medical Care Plans and Fees Committee allocation and a reduction to $3,500 of the Furniture and Fixture allocation. All other items in that portion to remain as set forth.

ACTION:

It was voted to delete the $300 allocation for meals from the Medical Care Plans and Fees Committee budget.

It was voted to reduce the Furniture and Fixtures allocation to $3,500.

Burt O. Wade reported that his group recommended that the 1963 Legislative Assessment be incorporated in the dues and entered a strong protest to deficit spending. They recommended that the dues as approved by the Council be set at $100.

ACTION:

It was voted to incorporate the 1963 Legislative Assessment into the dues and to set the 1964 dues at $100, as recommended by the Council.

FINAL ACTIONS

The Treasurer asked permission to incorporate the audited figures that are now available when the budget is published. The question arose whether the budget should be published in detail in the JOURNAL.

ACTION:

It was voted to publish the amended budget in the audited form. Dr. Sloan thanked the President for the previous day's luncheon.

It was voted that this Body go on record as thanking the President for setting up such a nice luncheon.

Dr. Kim questioned the wisdom of publishing the minutes in the JOURNAL. Dr. West advised that he would take this up with the Council.

Dr. Chinn spoke of the exceptional cooperation we had received from the new auditor.

ACTION:

It was voted to send a letter of appreciation to Mr. Melvyn Leong.

Dr. West thanked the House for attending the two sessions and expressed the hope that at the next meeting in May there would be a more interesting session.

The meeting adjourned at 11:30 A.M.

* * *

The final approved Budget is as follows:

1963-64 BUDGET

INCOME	1963-64 APPROVED BUDGET	1963 ACTUAL 6 MOS.
Dues	$60,000.00	$34,596.50
JOURNAL	(3,467.00)	1,228.30
Annual Meeting	5,380.00	6,772.88
Miscellaneous	700.00	263.68
Legislative Assessment	4,000.00	11,087.00
Interest	1,800.00	862.30
Post AMA Meeting	5,000.00	.....
Total Income	$73,413.00	$54,810.66
Less Total Expense	75,110.00	30,878.65
Net + or —	$(1,697.00)	$23,932.01
EXPENSE		
AMA Convention	$ 2,910.00	$ 2,880.08
Audit & Accounting	1,580.00	1,040.00
Auto Expense	600.00	300.00
Committee Expense		
Arrangements†	.....	.....
AMA-ERF	.....	.....
Awards	.....	.....
Bylaws & Parliamentary	.....	.....
Cancer	.....	.....
Careers	370.00	11.22
Chronic Illness & Aging	.....	.....
Com. Diseases & Immun.	.....	.....
Crippled Children	.....	.....
Diabetes	340.00	2.57
Disaster	.....	.....
Federal Medical Service	.....	.....
Hawaiian Academy of Science	150.00	150.00
Heart	.....	.....
Hospital Liaison	.....	.....
Legislative	5,980.00	9,644.97
Maternal & Peri-Natal Study Com.	300.00	.....
Medical Care Pl. & Fees	7,420.00	1,243.38
Mental Health	500.00	300.47*
Nurses' Liaison	.....	.....
Postconvention	250.00	.....
Public Relations	16,430.00	2,066.54
Health Education	.....	552.56
Radiation	.....	.....
Scientific Program†	.....	.....
School Health	.....	.....
Tuberculosis	.....	.....
Venereal Disease	.....	.....
Woman's Auxiliary Liaison	.....	.....
Nominating	.....	.....
Ad hoc Committees		
Investigation	500.00	.....‡
As. of Prof.	100.00	.....
Council Expense		
Travel	280.00	91.08
Meals	230.00	68.17
Per Diem	180.00	80.00
Donations	20.00	20.00
Insurance	400.00	97.41
Library Contribution	100.00	.....
Postage	.....	866.12
Stamps	900.00	.....
Bulk Mailings	300.00	.....
Permit	20.00	.....
Rent	1,850.00	924.00
Repairs & Maintenance	150.00	109.82
Reserve Funds		
Entertainment	400.00	138.64
Moving	.....	.....
Miscellaneous	470.00	98.44
President's Contingent Fund	500.00	304.07
Furniture & Fixtures	3,500.00	144.80
Retirement	570.00	.....
Salaries	27,190.00	10,311.90
Stationery, Printing & Supplies	1,500.00	586.93
Subscriptions & Dues	840.00	269.00
Taxes	650.00	344.47
Telephone & Cables	1,500.00	389.93
Woman's Auxiliary	3,000.00	2,853.50
Travel	150.00	134.62
Total Expenses	$82,130.00	$36,024.69
Less JOURNAL Reimbursement	(7,020.00)	(3,598.56)
Less Miscellaneous Reimbursement	.....	(1,547.48)
TOTAL EXPENSE	$75,110.00	$30,878.65

* To be adjusted.
† See Income (annual meeting).
‡ Included in President's Contingency Fund.

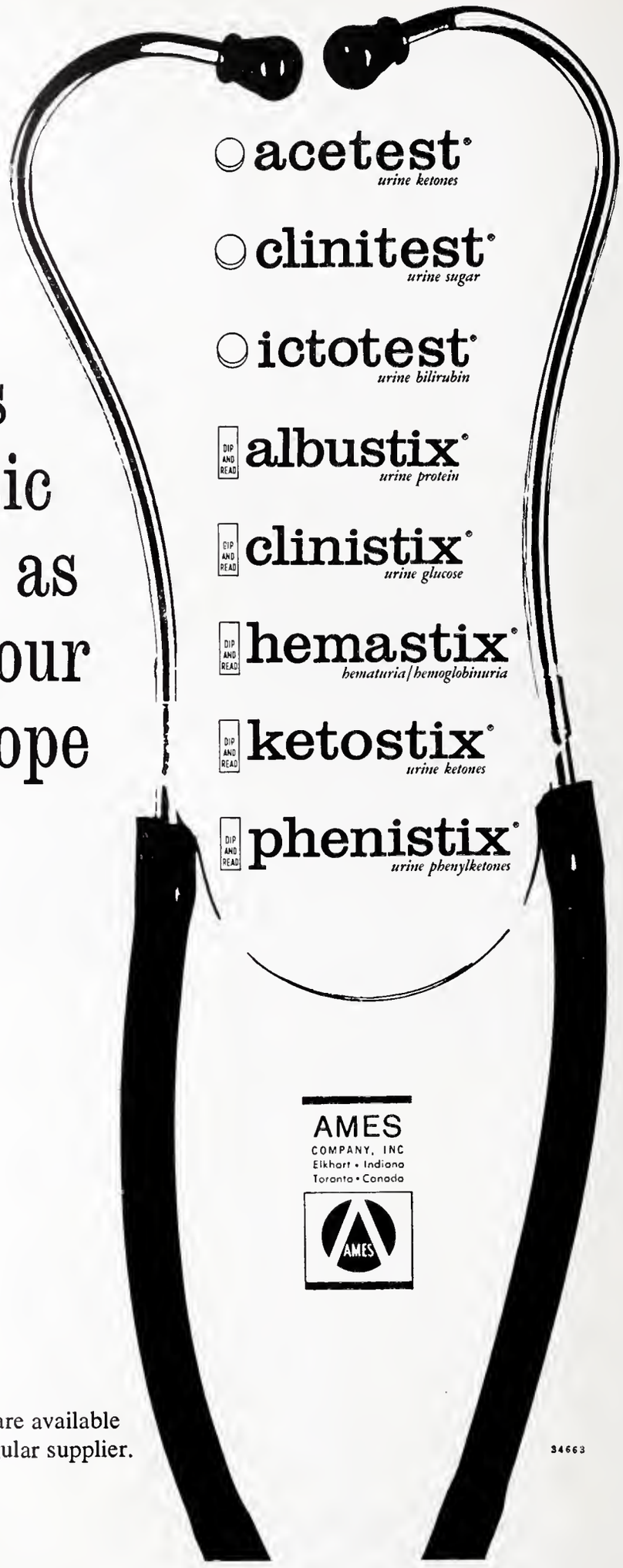
ANNUAL MEETING	1963-64 APPROVED BUDGET	1963 ACTUAL 6 MOS.
Registration		
Income	$ 4,000.00	$ 4,277.50
Expenses		
Telephone	50.00	43.54
Badges	150.00	17.55
Hotel, Meals, Entertainment	100.00	.....
Printing	450.00	438.69
Stationery & Supplies	150.00	13.98
Travel	.....	.....
Speakers	.....	.....
Wages	70.00	65.65
Miscellaneous	100.00	75.85
	$ 1,070.00	$ 655.26
Income over Expenses	2,930.00	3,622.24
Breakfasts		
Income	$ 800.00	$ 841.50
Expense	800.00	748.00
Income over Expense	.....	$ 93.50
Banquet		
Income	$ 1,500.00	$ 1,513.00
Expenses		
Miscellaneous	100.00	29.25
Music	200.00	200.00
Liquor	350.00	339.99
Dinner	750.00	626.50
Leis	100.00	71.58
	$ 1,500.00	$ 1,267.32
Income over Expenses	.....	245.68
Picnic		
Income	$ 350.00	$ 357.00
Expenses		
Miscellaneous	50.00	58.66
Lunches	260.00	225.00
Beer	40.00	34.94
Liquor	.....	151.29
	$ 350.00	$ 469.89
Income over Expenses	.....	(112.89)
Exhibits		
Income	$ 4,000.00	$ 4,500.00
Expenses		
Signs	100.00	33.64
Rental of Booths	1,400.00	1,540.00
Hauling	.....	.....
Wiring	.....	.....
Meeting Hall Rent	.....	.....
Miscellaneous	50.00	2.01
	$ 1,550.00	$ 1,575.65
Income over Expenses	2,450.00	2,924.55
TOTAL ANNUAL MEETING INCOME	$ 5,380.00	$ 6,772.88

COMMITTEES		
Diabetes		
Medical Technicians	$ 240.00	.....
Miscellaneous	100.00	2.57
	$ 340.00	$ 2.57
Hawaii Academy of Scient. (formerly included under Donations)		
Annual Contribution	$ 100.00	$ 150.00
Prizes ($25, $15, $10)	50.00	.....
	$ 150.00	$ 150.00
Legislative		
Counsel	$ 3,200.00	$ 6,000.00
Extended Session	.....	.....
Dinner & Entertainment	1,000.00	1,030.50
Mailings	650.00	.....
Public Relations Counsel	.....	1,200.00
Miscellaneous	250.00	261.17
Clerical	700.00	1,001.30
Taxes	30.00	.....
Today's Health	150.00	152.00
	$ 5,980.00	$ 9,644.97

	1963-64 APPROVED BUDGET	1963 ACTUAL 6 MOS.
Medical Care Plans & Fees		
Travel	.....	$ 132.63
Mailings	50.00	215.79
Envelopes	20.00	93.04
Cost of Questionnaires	50.00	229.81
Consultation Services	500.00	500.00
Editing	250.00	.....
Preparation of Data	750.00	.....
Interpretation of Data	250.00	.....
Random Sampling	1,000.00	.....
Data Processing	1,250.00	.....
Additional Runs	2,500.00	.....
Printing	800.00	72.11
Meals	.....	.....
	$ 7,420.00	$ 1,243.38
Public Relations (including Health Education)		
Press Awards	$ 100.00	$ 100.00
Radio	.....	.....
TV Program		
Sunday Ads	600.00	405.45
Daily Ads	.....	.....
Moderator	1,040.00	500.00
Special Films	400.00	.....
Special TV Programming	1,000.00	.....
Message of the Month	4,200.00	.....
Miscellaneous Flyers	400.00	.....
Miscellaneous	.....	107.85
Miscellaneous Printing	350.00	105.80
Press & Other Ent.	250.00	.....
Travel	500.00	.....
Photo Costs	100.00	.....
Counsel	6,000.00	1,800.00
Conference Expense	480.00	.....
MSEA Dues	10.00	.....
Miscellaneous Newspaper Ads	1,000.00	.....
	$16,430.00	$ 3,019.10
Less Video Tapes Sold		400.00
		$ 2,619.10

JOURNAL		
Income		
Advertising		
National	$17,000.00	$ 7,319.77
Local	5,000.00	3,102.75
Sales & Subscriptions		
Members	.....	3,528.00
Nonmembers	.....	326.50
Trans. 1963 Members	1,800.00	.....
Trans. 1963 Nonmembers	150.00	.....
Trans. 1964 Members	1,800.00	.....
Trans. 1963-64 Nonmembers	350.00	.....
Due from HCMS		
Extra Printing Costs	433.00	.....
200 Extra Copies at 50¢	100.00	.....
	$26,633.00	$14,277.02
Expense		
Automobile	$ 100.00	$ 150.00
Commissions Paid (Local Ads)	900.00	350.00
Discounts Allowed (National)	2,770.00	1,297.16
Miscellaneous	50.00	4.02
Postage	300.00	150.98
Printing	18,500.00	7,626.16
Rent	600.00	462.00
Salaries	6,000.00	2,766.29
Stationery & Supplies	50.00	13.84
Telephone & Cables	180.00	120.00
Taxes	120.00	100.27
Travel	500.00	.....
Copyrights	30.00	8.00
	$30,100.00	$13,048.72
EXPENSE OVER INCOME	(3,467.00)	1,228.30

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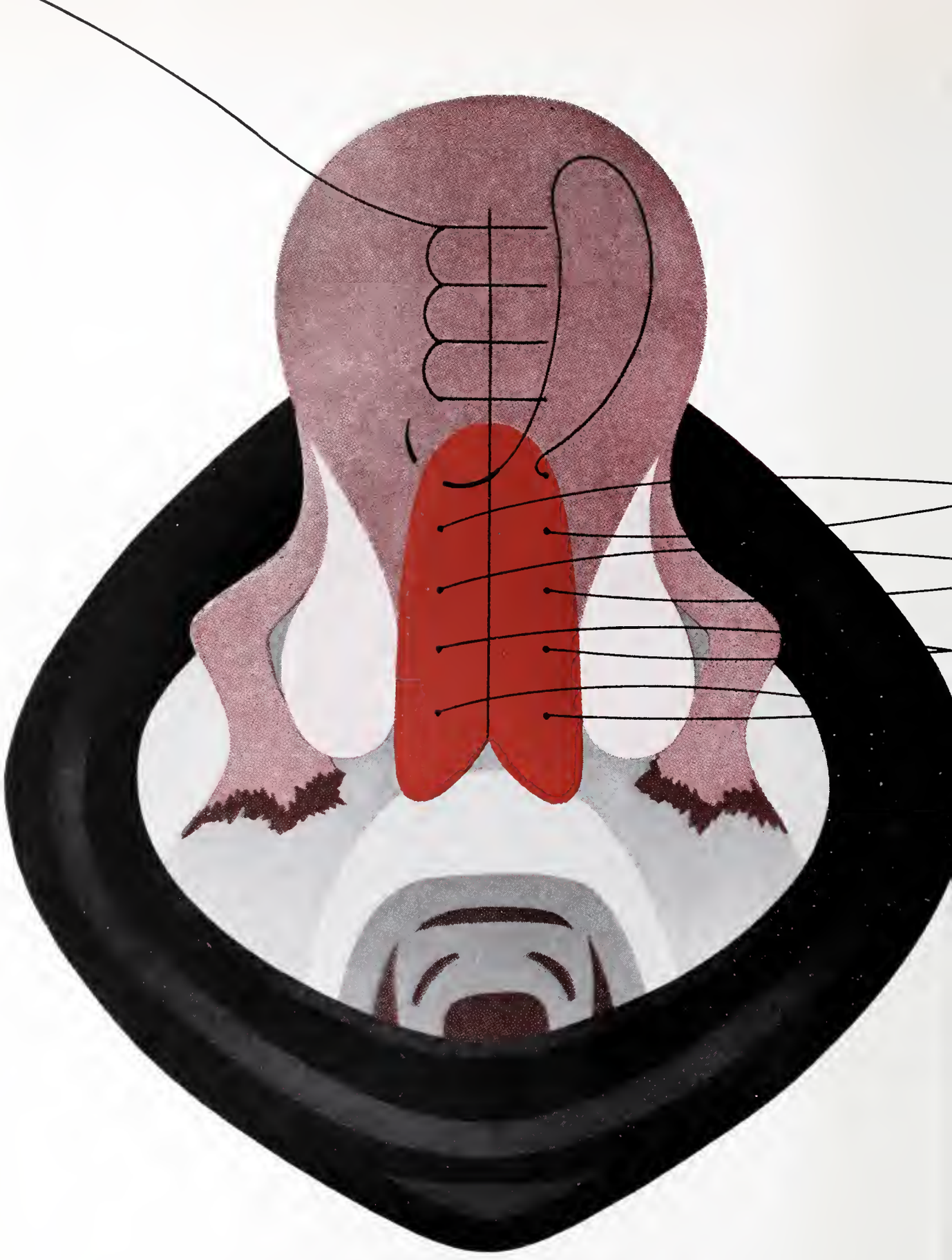
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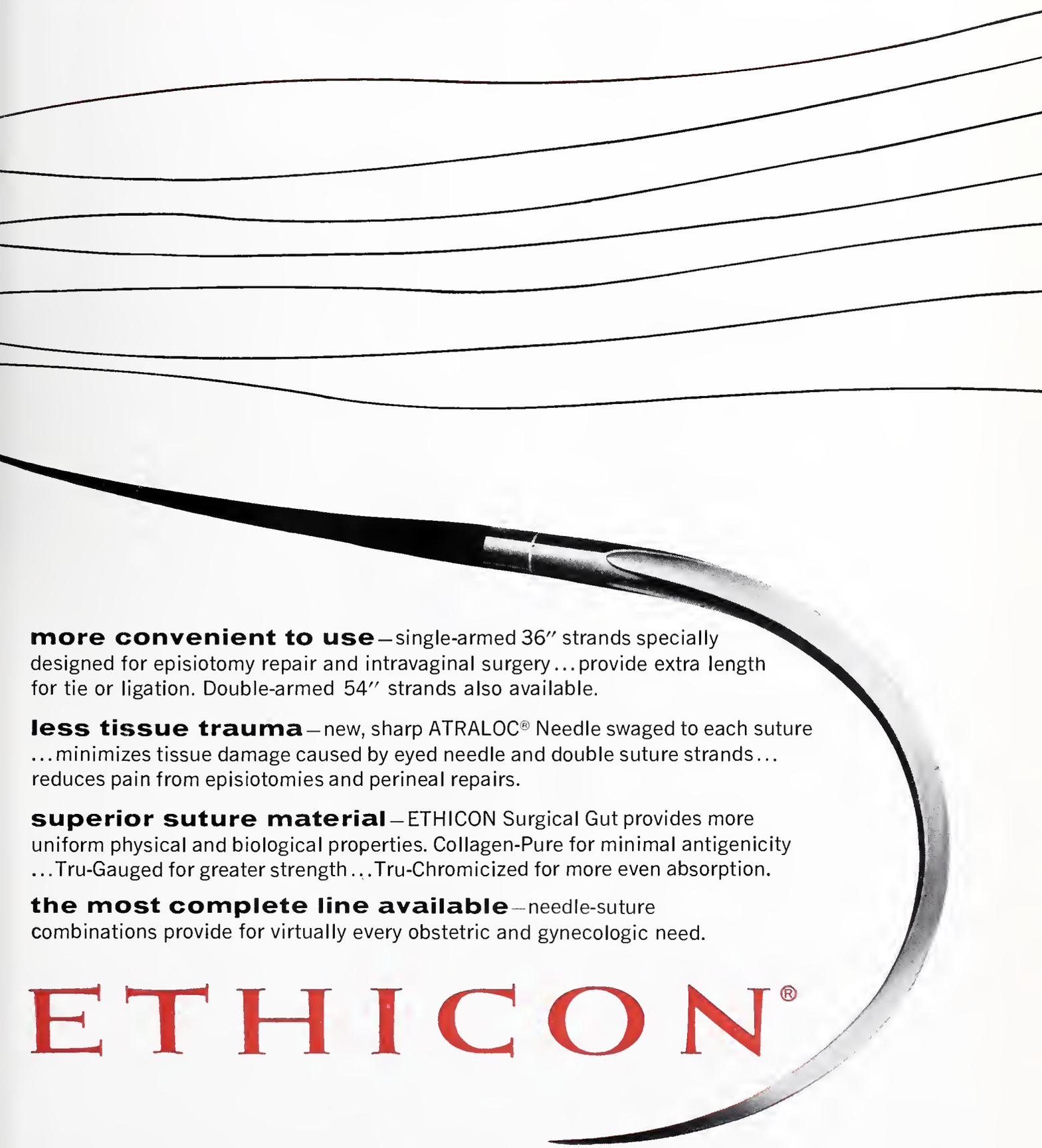
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Book Reviews *continued from 134*

tal problem resulting from genetic factors, counseling is becoming ever more important in the practice of medicine. The book is written in a chatty, informal way, but the reader will gain a good understanding of the relevant basic principles of genetics and how to use them in answering the many questions which reach the physician from many sources. Illustrative examples are given at the end of each chapter, and involve not only counseling for parents of affected children, but also for adoption agency personnel, for young people in the pre-marital period, for instances involving disputed paternity, and others.

The author has wisely refrained from giving a long list of empirical risks for diseases where clear genetic ratios are not readily available, or where the genetic background is heterogeneous. In its place he has provided, for each of some 300 rare genetic diseases, a complete reference to the most recent and important paper.

LAURENCE H. SNYDER, Sc.D.

Surgery

By Richard Warren, M.D., 1397 pp., $19.50, W. B. Saunders Company, 1963.

THIS BOOK is, in effect, a text, primarily oriented for the student of medicine. As such, it presents the broad aspects of surgery in a lucid and adequately comprehensive manner.

It may also be beneficial for the nonspecialist to orient himself regarding the basic patho-physiology and general treatment outlines of various surgical diseases. It will not find significant use by the general surgeon.

ROBERT A. ROSE, M.D.

Moving Field Radiation Therapy

By Felix Wachsmann and Gunther Barth, 265 pp., $10.95, The University of Chicago Press, 1963.

THERAPEUTIC RADIOLOGISTS will find the book fascinating to scan but may find reading certain chapters in detail as tedious and exacting as the subject itself.

Because rotational therapy is less frequently used in the United States than in Europe, the book fills a gap in the English radiological literature. The extensive bibliography (494 references) is drawn primarily from German sources.

The authors may overstate the case for moving field therapy in applying various techniques to an almost unlimited number of clinical situations, yet their arguments are presented in a convincing manner. The reader will be impressed by the required meticulous attention to detail in this form of therapy.

The book is recommended for therapeutic radiologists for both general interest and specific application.

R. G. RIGLER, M.D.

★Handbook of Pediatric Medical Emergencies, 3rd Ed.

By Adolph G. DeSanctis, M.D., and Charles Varga, M.D., and Contributors, 457 pp., $12.75, The C. V. Mosby Company, 1963.

THIS EDITION appears to be an outstanding, comprehensive emergency handbook. Emergency procedures and therapy for systemic problems as respiratory, neurological, and genitourinary tract are presented, including chapters on symptoms of shock and hemorrhage. There is a complete revision of the chapter on metabolic emergencies, with detailed outlines of respiratory and metabolic

continued page 154

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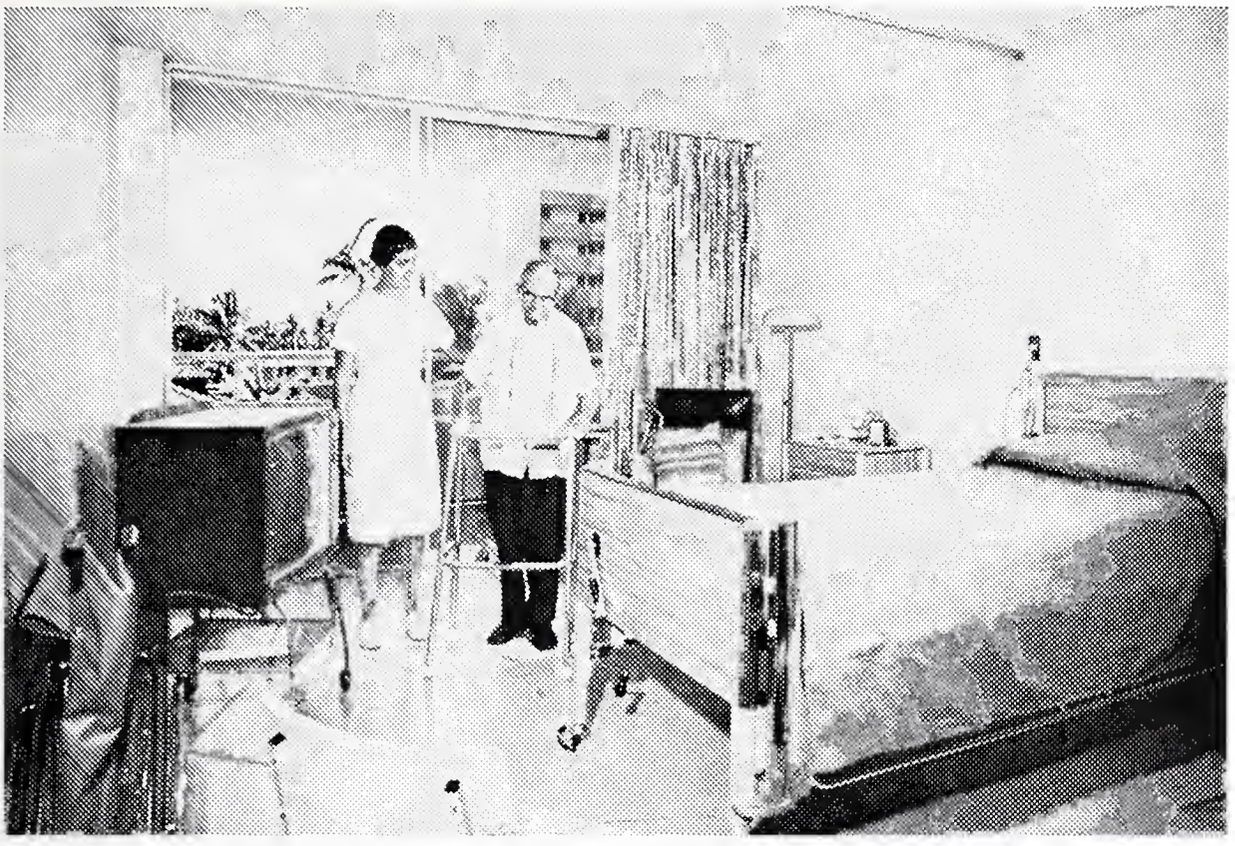
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alkalosis or acidosis. The lead chapter on cardiovascular emergency has also been revised, with concise statements on emergency therapy. Specific references are given at the end of many of the chapters. It is noteworthy that two new chapters have been added, dealing with emergencies of the newborn and the psychiatric emergencies.

The appendix contains references on commercial sources of poisons, doses of drugs commonly used in emergencies, and useful guides for drug and fluid therapy. In addition, there is some discussion of the physician's responsibility in cases of poisoning and accident prevention. The new handbook is much more comprehensive than its former edition and is highly recommended for emergency rooms of hospitals or clinics. It is easy reading and written in an outline fashion with many simple charts, pictures and tables for quick reference.

CALVIN C. J. SIA, M.D.

Applied Anatomy of the Eye

By Alfred Kestenbaum, M.D., 283 pp., $12.50, Grune & Stratton, 1963.

THIS VOLUME DEALS with the physiology and surgery as well as the anatomy per se of the eye, and therefore can be considered as a functional treatise on this subject. It is an excellent reference for any student of neuro-ophthalmology. For ophthalmologists interested in glaucoma, and in glaucoma surgery, the treatise on "limbus trapezium" is most valuable.

The illustrations are well done, and are easy to follow. They offer a new method of explaining anatomical relationships. This volume is a valuable contribution to ophthalmology and in my opinion an excellent reference manual.

PHILIP M. CORBOY, M.D.

Also Received

An Atlas of Hemodynamics of the Cardiovascular System

By Howard L. Moscovitz, Ephraim Donoso, Ira J. Gelb, Robert J. Wilder, 277 pp., $11.75, Grune & Stratton, Inc., 1963.

CARDIOVASCULAR physiologists will find much of interest in this beautifully illustrated volume.

Professional School Psychology, Vol. II

Edited by Monroe G. Gottsegen and Gloria B. Gottsegen, 354 pp., $9.75, Grune & Stratton, Inc., 1963.

NOT FOR us ordinary mortals—but a must for those in the field.

External Infections of the Eye

By Helena Biantovskaya Fedukowics, 228 pp., $16.50, Appleton-Century-Crofts, 1963.

CYTOLOGY and bacteriology are related to clinical and funduscopic lesions in 42 full-page plates, almost all in color.

Applied Anatomy of the Eye

By Alfred Kestenbaum, M.D., 292 pp., $12.50, Grune & Stratton, Inc., 1963.

A TEXTBOOK with many excellent, vivid, explanatory diagrams.

British Medical Bulletin, Vol. 19, No. 2

Medical Department, The British Council, May, 1963.

TWELVE PAPERS on peripheral circulation in man, illustrated with charts and line drawings.

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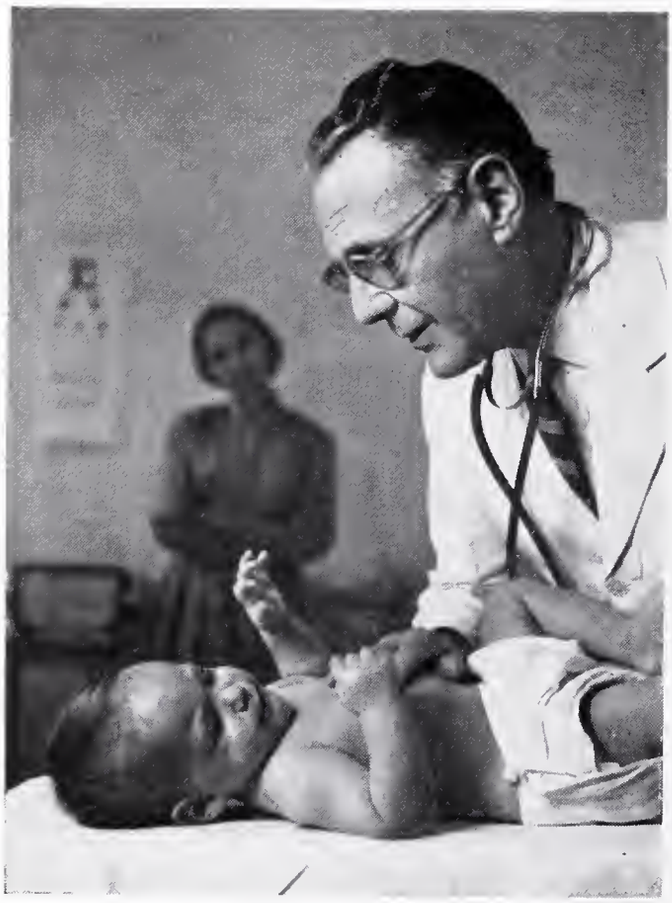
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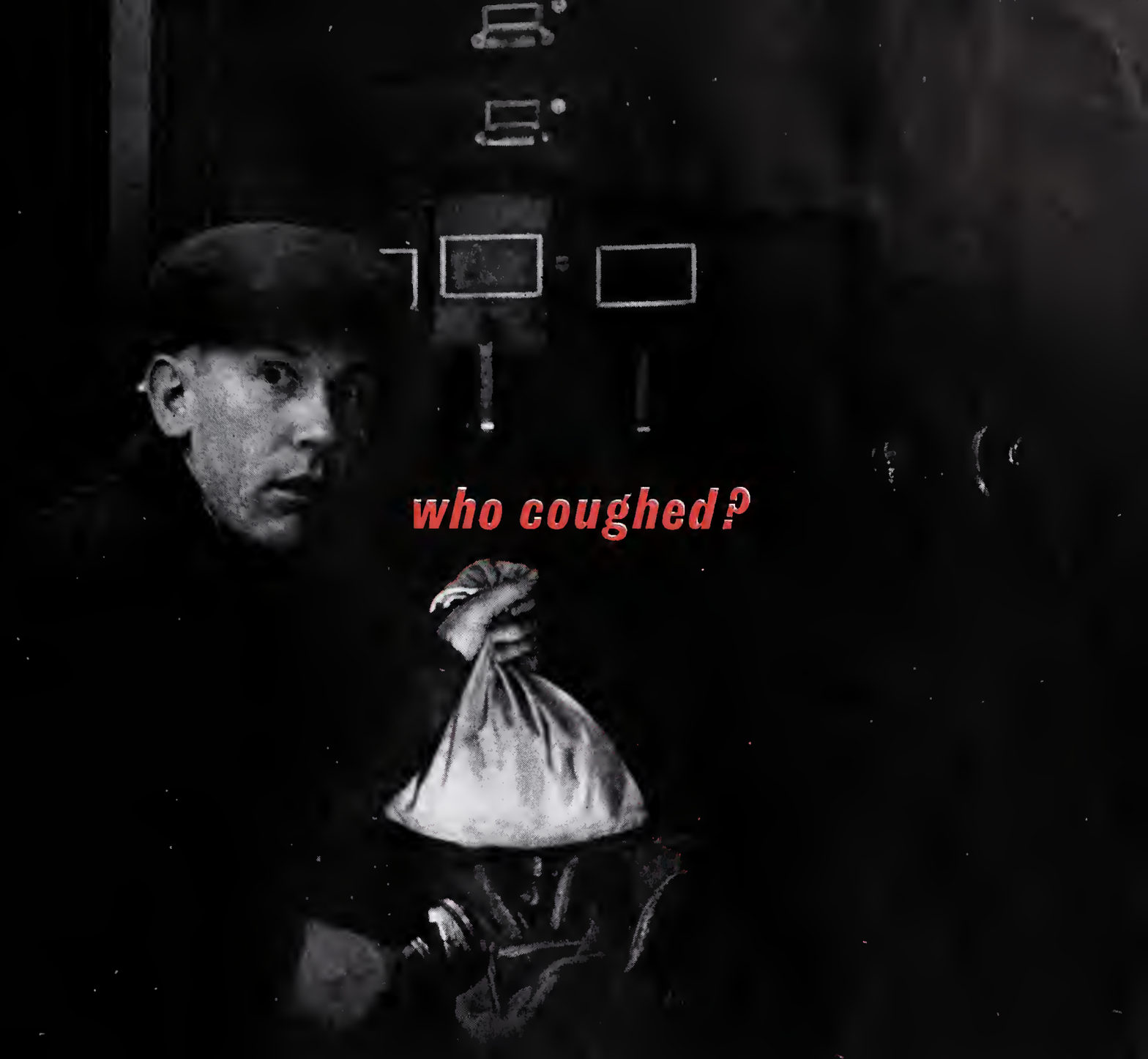
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References: 1. Wilson, J. F; Heiner, D. C., and Lahey, M. E.: J. Pediat. 60:787, 1962. **2.** Committee on Nutrition, Collected Reprints, 1956-1962, Evanston, Ill., American Academy of Pediatrics, 1963, p. 45. **3.** Beal, V. A.: Pediatrics 20:448, 1957. **4.** Reisner, E. H., Jr.: Penn. Med. J.: 63:49, 1960. **5.** Marsh, A., et al.: Pediatrics 24:404, 1959.

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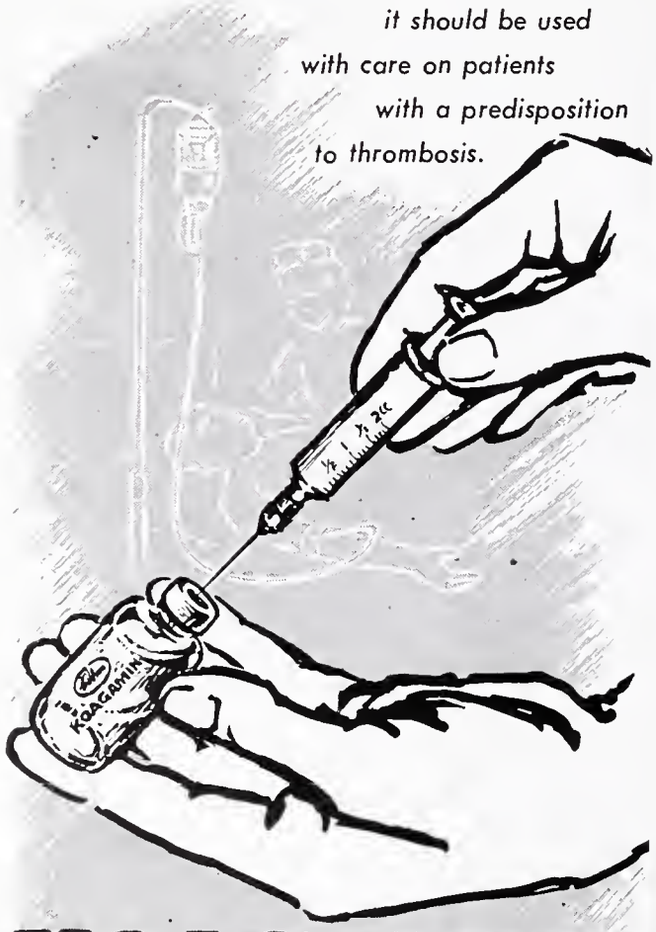
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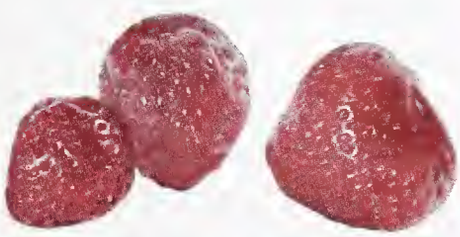
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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Hawaii Technologists' Bulletin

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References: **1.** Soss, T. L., in Colleet. Letters, Internat. Cor. Soc., Ophthalmologists & Otolaryngologists 3:177, Dec. 15, 1958. **2.** Budetti, J. A., and Seydell, E. M.: *J. Kansas M. Soc.* 57:59, Feb., 1956.

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Correspondence

Professional Health Planning

To The Editor:

The September-October 1963 issue of the Hawaii Medical Journal just reached this office on Friday.

The Health Facilities Planning Council and staff is appreciative of the excellent editorial titled "Professional Health Planning." It is hoped that the practicing physicians will accept their Journal Editor's suggestion to submit constructive criticism. The HFPC realizes full well the necessity for the "support and cooperation" of physicians but, at the same time, recognizes its obligation to provide the members of the profession (along with all other segments of the community) with appropriate information about the Council's activities and its progress.

Thank you for this generous initial coverage.

Edward W. Colby, M.D., M.P.H.

High School Football: Valuable Sport

To the Editor:

About this time of year we always get that group of medical men, most of whom never played competitive sports, demanding deemphasis of high school sports. We have the psychiatrist bemoaning the emotional trauma done to a player when he loses a game; the men in pediatrics claiming all sorts of epiphyseal troubles; and a few gynecologists claiming it is a shame we permit contact sports.

Doctor Frank L. Tabrah is right, in that we should all enjoy individual type sports such as golf, tennis and hunting for our "later" years. But, we are not all loners. Some children need a rough contact sport. They are group oriented and need team activities. Many children are getting rid of hostility in being able to play football, instead of building it up.

We do not need less physical activities, we need more! We have enough students sitting and watching others do things. All should be active in some sport. Not all should play football, but competitive activities will do more good than harm. We have enough weak and "nervous" individuals in society today; maybe some form of competition in high school, besides chess or tiddly winks, would strengthen their back bones for later life.

It would be good to have Doctor Tabrah read the ten year report by the New York State Athletic Association on Junior High School sports. This is a study involving over 16,000 boys, and with the help of New York State's Medical Society it is now accepted as a guide, and all junior high schools have now taken on a full athletic program. Too many physicians, not athletically oriented, are scaring parents with their remarks in magazines and newspapers, most of which have no basis for their findings.

Frank E. Barnes, Jr., M.D.

Smithfield, N. C.
November 25, 1963

Dr. Tabrah's reply follows:

Dr. Barnes, in his opening remarks, typical of letters of this sort, attacks people rather than the facts they present, and in baldly asserting they are not sportsmen, discloses little more than his perennial hostility to football critics.

We agree, happily, in paragraph 2.

In the first half of paragraph 3, Dr. Barnes beautifully supports my assertion that football is largely a spectator

continued page 234

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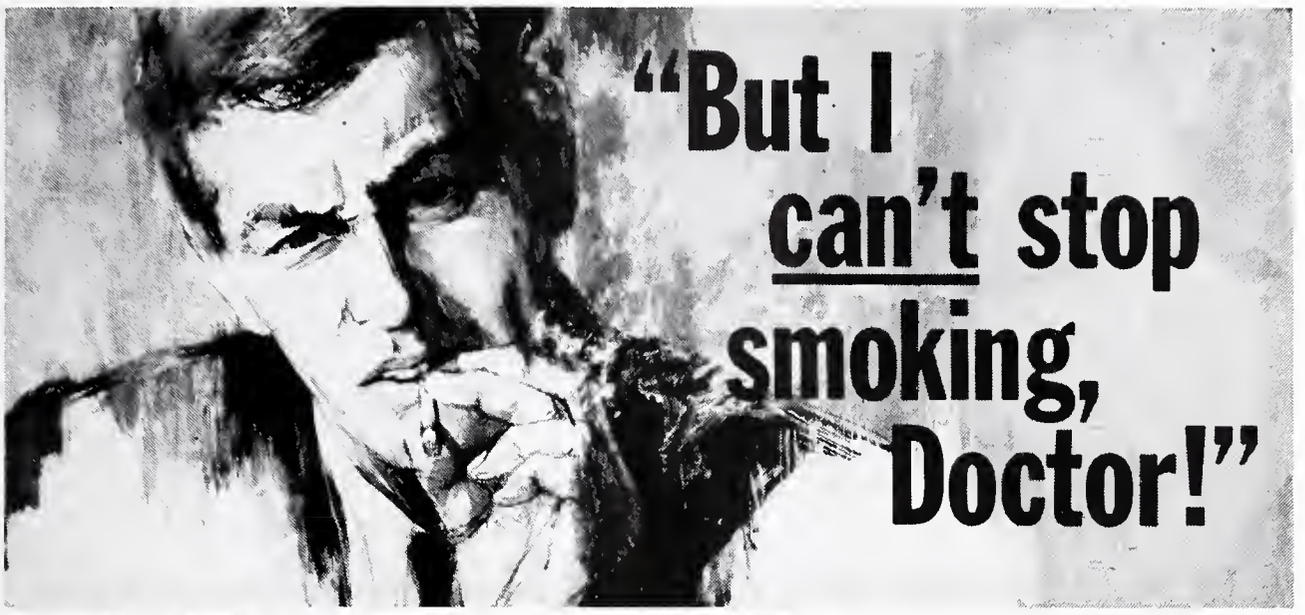
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Hawaii needs a mental health program
and it can have a good one.

Observations, Impressions, and Recommendations for Hawaii's Mental Health Program

EDWARD D. GREENWOOD, M.D.* *Topeka*

• *At the first Mental Health Conference to be held in Hawaii, participants concerned themselves with: childhood mental illness, alcoholism, psychiatric emergencies, the role of the family doctor, community facilities, legal aspects, and research and education. Dr. Greenwood summarizes the findings of these discussions, and contributes his own observations.*

DISCUSSION on Childhood and Mental Illness aired a great many common problems, and arrived at few, if any, firm conclusions. This is certainly not unusual in view of the broad scope of the topic.

The relationship of a child to its parents, of parents to a child, of parents to the community, and consideration of better ways of aiding children without constant attack on their parents claimed the attention of the group. A differentiation was made between "adult parents" and "biological parents."

TEEN-AGE PROBLEMS

Some of the problems children face are school anxiety, school phobia, or separation anxiety. Community reaction to teen-agers and their problems opens another explorable area. It is my hope that those dealing with teen-agers specifically will take a long, careful look at what is currently being done for them and what has been neglected. Remember that adolescence is a stage of growth and not a disease. Teen-agers suffer greatly when they find themselves unable to adjust as expected. They need help in self-understanding to ease the transition to adulthood.

What is the status of community facilities for children and adolescents at present? Here in the islands as well as in many other areas of the United States, appropriate facilities are either totally lacking or painfully inadequate. The inadequacy may derive either from size, lack of qualified staff, quality of service offered, or from all. If changes are to be instituted, a serious appraisal of present conditions needs to be made. There is a big difference between busy work and real service. It must be recognized that the provision for better children's services requires a constant re-examination of what is being done. Any program set up for five or ten years would soon prove worthless without careful evaluation each year as to the degree of progress that is being made.

DRIFTING CHILDREN

The effects of population mobility, particularly of the military, in this island state, on children's adjustment to life has been considered. Many children have never known a permanent home. They have always been drifters, moving from place to place, always foreigners on different soils, in different states.

It is not the military group alone that is forced to move about. Some large corporations have a policy of staff rotation at five-year intervals. This may be good from the point of view of successful business, but certainly confronts children with a host of unnecessary difficulties. Not all succumb to

* Past President of the American Orthopsychiatric Association.
Presented at the 1st Mental Health Conference of the Hawaii Medical Association, June 25-26, 1963.

the additional stress of adjustment, but a large proportion do.

CHILD THERAPY

Therapy for children cannot be an isolated operation. Techniques must be adapted to the age of the child; and to be effective, the therapeutic process must include both parents, not one to the exclusion of the other. Progress, particularly with younger children, bears a definite relationship to the amount of understanding and help gained by parents either by way of case work or therapy.

This poses one of the major problems in working with children. Obviously, a great deal more staff time is required to treat one child than to treat one adult. If "suitable" therapy is to be carried out, it will be necessary to examine the many different techniques which are now being used and weigh them for effectiveness and desirability. Questions raised about individual therapy, group therapy, family therapy, or no therapy at all would have to be considered in the total context of the kind of service to be designed for specific kinds of children and adolescents. There are many variations and possibilities.

CONTINUUM OF SERVICES

It must be recognized that to accomplish the kind of work needed for children and adolescents, we need to look toward a total program of children's services. Just the establishment of a residential treatment center or the establishment of a mental health clinic or an all-purpose clinic, is not the answer. We must have a continuum of meaningful services ready for children at all stages in order to obtain effective results.

Early identification of problems at the nursery school or public school level is greatly needed. Guidance clinics must be provided as well as residential treatment centers and facilities for foster home placement. Half-way houses are needed for some children, week-end programs for others, and special treatment camps for still others. These are some of the basic services which should be established.

INTEGRATED PROGRAM NEEDED

Unfortunately many of our states have established only one or another parts of the chain of possible services. Such fragmented, limited services end in failure. Without a well-organized, integrated program, children's problems will continue to increase in amount and severity.

The development of an attitude of responsibility throughout the community, by every educational means, is a most important factor in the initiation and carrying out of a treatment program. The professional workers, the physician, and the entire medical profession must contribute time and energy toward this goal. Without adequate lay support, professional people who work for state, county, or city agencies become frustrated and give up their positions to return to private practice or private agencies.

PSYCHIATRIC EMERGENCY

Discussants of Psychiatric Emergency and First Aid began with an attempt to define the term "psychiatric emergency." Many definitions were given. One defined a psychiatric emergency as an emotional crisis in an individual's life, sufficiently disturbing to the person and people around him to require immediate help, either for him or for his family.

The general practitioner, in actuality, sees more psychiatric emergencies than does the average psychiatrist. As the family physician, he is called first and thus sees many patients in the throes of a severe anxiety state, acute manic state, or in a psychotic episode. Most practitioners are able to handle the acute phases. Later when adequate hospital placement for the patient is sought, the doctor may find that there are not enough beds available for psychiatric treatment. If outpatient treatment is required, the patient may find himself on a long waiting list.

Early signs of difficulty may be identified by any of a variety of professional people. Family physicians, clergymen, public health nurses, social workers, teachers, and psychologists see individuals in various situations and often can identify early signs of problems. Unfortunately, some patients are unwilling to accept care at that time and must go through an acute excitement phase before they are amenable to help.

PSYCHIATRY AND THE LAW

Regarding psychiatric admissions to hospitals, here law becomes closely allied with psychiatry, and the community concept of a psychiatric emergency needs to be understood. An acceptable interpretation of the law is a difficult hurdle for all concerned. More difficult is the ironing out of differences between lawyers, psychiatrists, and general practitioners.

Before effective changes in the laws can be made, these specialists will have to settle their own semantic differences. A common language instead of three separate vocabularies would be a good starting point. Quibbling over terms instead of searching for workable solutions to problems seems a shameful waste of talent.

If changes are to be made in the law, there must be a joint endeavor by those responsible for the law and those responsible for the mentally ill. A united front must be presented, without concern about who gets the credit for making the changes. This seems an all too obvious point, but great effort, intelligence, and maturity on the part of planners are demanded. Otherwise nothing transpires but talk.

CHANGING ROLE OF G.P.

Another of the discussions centered on the changing role or image of the general practitioner. He was once both doctor and counselor to those he served. He once knew the most intimate facts about each family, facts that never found their way into any filed report. He had many opportunities to build complete case histories over the years from birth to death. By seeing his patients in their own homes, the old family doctor knew how they really lived as well as how a given illness related to the home situation at a given time. Now because of heavier case loads, greater distances, and increased mobility, and given improved central facilities, the doctor confines the major part of his practice to his office and the hospital.

The Academy of General Practice has been established to help the generalist retain his identity and to help him keep abreast of changes and advances in his area. This is good. But it is hoped that this organization will not lead its membership to make the mistake made by certain specialty groups, which is isolation from the rest of the medical profession. Psychiatrists are now traveling the hard road back to acceptance by their fellow physicians.

COMMUNITY RESPONSIBILITY

One of the biggest problems at the present time is the changing image of the physician. In his new role he has a major contribution to make if he will make it. Most medical schools prepare students to do individual work with patients. Few stress the need for public health training wherein the public at large is the area of concern. It would seem that we need to modify our medical education program right from the beginning, taking into consideration the fact that the physician has a dual responsibility, to patient first, and to community second. His contribution in the latter area is broader by far than the mere practice of medical routines, for he is looked upon as a model citizen whose attitudes are copied by many others.

There is also a crying need for better orientation of physicians at large with regard to the concepts of prevention in mental illness. They should know what constitutes good mental health, what is meant by personality development, and why it is important for them to understand the total patient. The fever, the diseased organ, the broken leg are isolated factors that require immediate attention. This we know. But to treat them as though they were separate entities devoid of connection to a thinking, feeling human being is indeed shortsighted.

WHAT IS CURE?

It must be recognized that during an illness, a patient increases his dependency upon his physician. Many times this dependency is unrealistic, with expectations of improvement or cure far out of proportion to what can ever take place. Sometimes there is an overemphasis on the word "cure," despite the fact that a definition of "cure" is as elusive as a definition of truth or other abstractions. For the purpose of our discussion, "cure" is conceived of as giving a patient an opportunity to live a better life than he had been living prior to coming for treatment.

Factors of cost and time enter the picture when psychiatric treatment and cure are considered. No patient becomes ill overnight, nor does he recover miraculously overnight. Both processes cover a long span of time. And it is that long treatment program that raises the cost of service. The quality of the treatment also raises the cost.

There is the choice of providing good treatment for patients or continuing the haphazard, indifferent ways of providing custodial care and minimal treatment. A good number of our existing treatment programs have no right to use the word treatment at all. They are purely custodial facilities that isolate the sick from the total community and spare the well the embarrassment and discomfiture of observing the behavior of the less fortunate.

RECRUITMENT PROBLEMS

The problems of securing not only more personnel in the mental health profession, but also people of greater competency were considered. Perhaps we need to include additional disciplines. Some places have health educators, who come from the fields of education, nursing, and social work. All play a useful role in the total picture. No matter how many adjunctive groups there may be, however, the physician will have to retain the basic responsibility. He will have to be willing to supervise and guide these people so that they can perform the most effective work for the patients.

Points made by Dr. Kern* regarding mental health in England and the "open hospital" projects

* Howard M. Kern, Jr., M.D., Director, Demonstration Training Program in Community Psychiatry, Johns Hopkins University School of Medicine, a participant.

there led to the suggestion to transport this kind of approach to the United States. It might be possible to move in the direction of more open hospitals, provided that we change our philosophy of hospital treatment and we educate the public as to the values and problems connected with such changes.

PUBLIC EDUCATION

Much discussion concerned public education and communication. I should like to comment briefly about what I consider a prerequisite before any popular program is attempted. This concerns the development of mutual respect between people within the profession. The feeling must go deeper than the superficially nice words that even in their niceness sometimes fail to cover the animosity harbored by so many co-workers. In our country, differences of opinion will always exist. This is a healthy, desirable state, one that keeps us alert. Learning to understand one another, to tolerate, if not accept differences, and to work together toward a common goal should be a primary aim for all of us. One cannot expect patients or the surrounding community to have respect for us as physicians or for our paramedical colleagues, if we have little respect for one another.

HAWAII'S PROBLEMS

After looking over some of the local records and visiting one or two institutions on Oahu briefly, I have the uncomfortable feeling that some of the things cited as progress by the workers are really extensions of the truth wrapped up in wishful thinking. I'm quite sure that people doing the work in the local hospitals are dedicated people. They are trying to do the very best they can in spite of a variety of handicaps, such as inadequate personnel, inadequate funds, and inadequate housing.

Hawaii is not alone in having to admit that its programs are far from satisfactory. Most sincerely, I say that I am not in any way trying to belittle the efforts many of you are making or to belittle the dedicated work you are doing. I simply say what you already know. There is a great deal more that needs to be done.

With the population continuing to increase as rapidly as it is, the urgency of the problem becomes acute. There must be well-organized agencies, hospitals, guidance centers, all-purpose clinics functioning and ready to care for the ill before they become chronic patients, or there will never be buildings large enough or rocking chairs sturdy enough to meet the needs of the custodial influx.

Since Hawaii, outside the limits of Honolulu, consists mainly of a rural population, there are special problems to be met in providing services for all. Traveling clinics are one possibility. Specialized service by public health nurses is another. There is also the possibility that some general practitioners would be willing to undertake community services outside the immediate Honolulu area.

Care must be taken, however, to assay the problems and needs of the small community. The attempt to transplant big city planning techniques to rural areas would be a sad mistake.

RECOMMENDATIONS

I shall review the recommendations compiled by the various discussion groups. In all but one group, emphasis on public education was the primary recommendation. No one can doubt its importance. With cooperation between volunteer groups and psychiatric and general medical societies, much could be accomplished.

A second recommendation concerned the salaries for professional personnel. It was hoped that they could be raised at least to the university level, if not higher. A third recommendation involved the role of the psychiatrist as consultant and educator. Under his supervision and leadership, members of other disciplines would carry out the necessary procedures. His would be the major responsibility for coordinating the program for each patient.

I have been impressed with the tone and quality of these discussions. Genuinely interested persons were trying to find better ways to serve people. Everyone seemed to realize that changes would have to be made if higher goals were to be achieved.

An obvious area of tension was uncovered when problems about funds were discussed. That money is needed for good facilities and adequately trained staff has been an accepted fact. But I had the feeling that there was considerable friction between programs within the State over the varying amounts allotted for their work. Whether this reflected sibling rivalry between agencies or rivalry between the informed and the uninformed, I could not be certain.

It is my impression that the rivalry is closely akin to that experienced in families with children of varying ages. The oldest agency assumes the greatest priority, responsibility, and authority by virtue of age alone. And that is scarcely the best criterion. On the other hand, the rivalry may derive from the fact that more money is available for one agency than for another simply because of some quirk in the state budgeting. Many resentments grow from such imbalance.

I feel very strongly that there is a great need for communication, the frank and open exchange of information and ideas. Communication is a two-

way experience. Unfortunately, too many of us tend to substitute the one-way system of talking to or at someone else, with our ears and minds closed to any response that someone might make. Until real communication occurs, much effort and energy will be wasted.

A sign of group maturity is its ability to really discuss any and all issues without excessive hostility. We tend to "personalize" unpleasant issues, thereby defeating the purpose of discussion. Instead of openly facing an unacceptable or upsetting idea, we sometimes want to attack or ban the person who brought it to our attention. This happens all too frequently. When it does, we need to take a closer look at our personal and group level of maturity.

Continuing now with the recommendations, I want to stress again the importance of the general practitioner in the mental health picture. Open communication routes could certainly profit all in the area. We need a two-way sharing of knowledge instead of one group trying constantly to be the informants. There is so much that could be learned from doctors in general practice if they were encouraged to speak.

It would be more satisfying to end this discussion on a comfortable, pleasant note; but in all fairness, I cannot do so. If I tread hard on a few toes, it is because I really want to challenge people to stand up and fight, if they have any faith in the work to be done.

First, I think it should be recognized that the construction of a worthwhile mental health program can never be a one-man job. It must be a cooperative endeavor. If future conferences on mental health are to be held in Hawaii, it would be highly desirable to have all the people and all the key organizations who are to be present be involved in the planning, steering, and operation of the program. I know how very difficult it is to deal effectively with large, complex groups; but nevertheless, people do a better job if they participate in the planning. The provision of adequate mental health facilities is a burgeoning problem at best. Why compound the problems by adding petty factionalism? There is no longer any time left for personality and agency wars.

BOYS' SCHOOL SHOCKING

During my stay here, I was privileged to visit several institutions. In one of them (the Boys' Training School—Ed.) I saw practices that I thought had long since been abandoned as bad and useless. I was both shocked and depressed. The saddest aspect of it all was the feeling that the institutional personnel were guided not by reason, but by fear.

To allow public opinion to force us to behave contrary to the dictates of intelligent thought is an escape for cowards. All of us are cowardly at times, but when it means the difference between good and poor service to people, we must learn to be strong. Instead of bowing to the demands of so-called great, uneducated power, the "public," we must learn to make use of the people at large in a positive fashion. Bring the public in, teach them with words and demonstrations, outline your goals, your hopes. Ask them to help. Capitalize on their talents and strength. With them in the planning, you have a formidable ally instead of a fault-finding, hypercritical enemy.

Finally, let me thank the conference planning committee. They have taken the first giant step. I hope they will take many more. An ideal location for future planning might be on top of the Pali from whose broad vantage point intelligent planners might be reminded to look objectively in all directions in an attempt to see issues unemotionally from many sides and from a variety of levels. The job to be done in Hawaii is a big one; and the time is now, not five years hence. ■

Care of the Mentally Ill *is* Expensive

According to Public Health Service estimates, 17 to 18 million persons in the U.S., about one in ten, are mentally ill enough to warrant psychiatric treatment. A recent private study of a New York City neighborhood indicates the problem is even deeper. Four out of five of the 175,000 persons surveyed were judged to have some mental disturbance. The study indicated further that low income persons have more mental illness than those with high incomes.

The Department of Health, Education and Welfare reports that during 1962 more than $2.4 billion in tax revenue was spent in direct governmental outlays for treatment of mental illness and retardation. This is only part of the picture. It does not take into account the cost of care in private mental hospitals and general hospitals, treatment by private psychiatrists and general practitioners, the cost of psychiatric drugs for ambulatory patients, public welfare expenses, and the untold waste of human resources.

An estimated one million or more patients are hospitalized for mental disorders each year in public and private facilities, taking up approximately half the hospital beds in the U.S.

From *Health Economics*, December 26, 1963

The chronic, long-term mental patient at Kaneohe State Hospital is not the rule, but the rare exception.

Patients' Progress:

A Study of Release and Retention of First Admissions to Hawaii State Hospital

JOHN B. ENRIGHT, Ph.D.,[1] *Torrance, California*

• *The vast majority of patients admitted to Hawaii State Hospital at Kaneohe go home after a short stay—nearly half of them within six months, 60 per cent in less than a year, 80 per cent in two to four years. The statistical evaluation of this is complex, but one fact emerges clearly: hospitalization for mental illness is not "the end of the line" for the great majority of patients.*

IF ONE computed the average length of stay in the hospital of all the patients in Hawaii State Hospital at Kaneohe today, he would find it to be several years. If he traced the future fate of this group of patients, he would find that many of them remained in the hospital until death. From these facts, apparently, spring the widely held impressions people have about the hopelessness of mental illness.[2] The implicit logic seems to be:

> Patients at Kaneohe stay there for years
> X is going to be a patient at Kaneohe
> X will stay there for years

The fallacy in this logic can be clarified by a simple but important statement: All the patients *in* a hospital at any given time do not constitute a fair sample of patients who *have been admitted* to the hospital. As will be shown in detail herein, the vast majority of patients admitted to Hawaii State Hospital each year are discharged, most of them reasonably rapidly. Though only a small minority is left behind each year to swell the ranks of the long-staying patients, after enough years these atypical patients that remain a long time outnumber the others, and are responsible for the impression of incurable chronicity that pervades thinking about the mental patient in the State Hospital.

Questions about the probable fate of a patient admitted to a state hospital—that is, his chances of discharge and return, his length of stay, etc.—cannot be answered by studying the atypical subgroup of patients left behind in the hospital. The proper method is to trace the hospital and post-discharge course of *all* of a group of patients admitted during some period of time. The present paper will present the results of a study of the cohort[3] of patients admitted for the first time to Hawaii State Hospital[4] during fiscal year 1957—i.e. July 1, 1956 through June 30, 1957.

This cohort of first admissions includes 259 patients. Both this total, and the sex distribution of 145 men and 114 women were reasonably typical of this period in the hospital's history. To trace the history of a cohort such as this is a complex task, and it is easy to lose sight of the pattern while following the individual strands of data. It might be helpful to give an impressionistic account of the history of the cohort, before presenting the detailed analysis.

Of the 259 patients admitted during the year, many were discharged very quickly, and a few died in the hospital shortly after admission. As time passed, patients continued to be discharged from the hospital, though at a slightly decreasing rate. In the meantime, however, some of those members discharged early were readmitted; some to stay, some to die, and most to be redischarged. And, of course, a few of these were to be re-admitted yet again.

At any given moment, some members of the cohort will be in the hospital without ever having

Some of these data were previously reported in Volume II of the Research Reports issued by the hospital Department of Psychology. The present report presents more detailed, and in some cases more appropriate, analyses of the data. The occasional discrepancies of one or two cases between the present and previous reports result either from changes in classification of the small residual groups (e.g. "died on escape" or "returned and repatriated") that plague a study of this kind, or errors of tabulation in the original report.

[1] At the time the data for this study were gathered, the author was staff psychologist at Hawaii State Hospital.

[2] To investigate the impressions people have of the hopelessness of mental illness, the writer has informally asked many people in Hawaii the question "what proportion of patients admitted to Kaneohe for the first time are likely ever to receive a discharge?" Typically, estimates fall between 40% and 50%, with many pessimists guessing much lower. Even people who have had the experience of having a friend or relative receive a discharge quickly often demonstrate a kind of pluralistic ignorance by believing that the case they know is an exceptional one, and that most patients do remain a long time.

[3] A group of patients who share some common characteristics, such as being born during the same period of time, or becoming ill during the same period, is commonly called a "cohort," and a fairly well-established methodology exists for investigating what happens to the members of a cohort.

[4] Some of these patients had been admitted to other mental hospitals previously, either for a previous illness, or as a result of the current illness.

TABLE 1.—*Number of patients admitted for first time in 1957, by sex and diagnostic group, and median age of each group.*

	SCHIZOPHRENIC			ORGANIC			ALCOHOLIC			OTHER			TOTAL		
	M	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*
Number of patients	48	56	**104**	39	19	**58**	34	5	**39**	24	34	**58**	145	114	**259**
Median age	33	31	**33**	60	61	**61**	45	43	**45**	41	47	**46**	45	38	**42**

been discharged (continuously retained); others will be in after return from a previous discharge. Those out of the hospital might have been in once and never returned after their discharge; others might have passed through the hospital one or more additional times. Some patients will have died in the hospital, on their original admission or after a readmission; others will have died on discharge, thus removing themselves from the risk of return.

The relationship of the cohort to the hospital is always shifting as patients come and go; it is always possible that a patient continuously retained for many years will eventually be discharged; or a patient, out on discharge for years, eventually returned. There is no "final condition" of the cohort until all its members are dead; though after the first year in the hospital, the shifts in the status of the cohort will be less extensive than earlier. To complicate the picture further, it must be remembered that the members of the cohort vary in many characteristics, such as age, sex, and type of illness, and that what happens to a patient depends partly on these factors.

ANALYSIS IN DETAIL

The next few paragraphs will fill in this impressionistic description with a detailed presentation and analysis of the fate of the 1957 cohort. The number of patients involved is so small, compared with most studies of this kind, that some of the traditional methods of analysis cannot easily be applied, but an attempt will be made to present the data in a form that will allow comparisons with studies of cohorts in other areas, as well as describe the present cohort in a meaningful way.

Table 1 presents the number of patients in each of four broad diagnostic groups, and the median age for each group. The *Organic* group includes all patients suffering from acute or chronic brain syndromes, except those related to current *Alcoholism;* these patients are considered separately. The *Schizophrenic* group includes all subtypes. The *Other* group contains non-schizophrenic psychoties, psychoneuroties, sociopaths, and undiagnosed patients. If this last group seems too heterogeneous, it should be noted that psychoneuroties and sociopaths who reach a state hospital are not typical of their groups, and not always clearly distinguishable from each other or from psychoties. Each patient was classified according to his primary diagnosis, though in some cases the secondary diagnosis might be important in determining the outcome of hospitalization.

The only striking sex difference in frequency of diagnosis is the very low proportion of female alcoholics. A preponderance of males in this group is also seen in other communities,[5] though not to such an extreme degree as the present seven-to-one ratio. This ratio, however, does not seem out of line with other state hospital cohorts in Hawaii. It may be related in part to the accentuation within certain ethnic groups of prohibitions with respect to excessive drinking among women.

The finding that the youngest group is the schizophrenic is expected. A median age of 61 in the Organic group indicates the presence of many patients with the organic diseases associated with old age. Although the median ages are almost identical for the Alcholic and Other groups, the variability within each group is very different. The vast majority of Alcoholics are very close to the median, while the patients grouped under "Other" range from very young to very old.

STATUS EXAMINED

The status of each patient in the cohort on the same day, which happened to be October 16, 1961, was determined. Table 2 shows the location of patients in the cohort on that date. Twenty-nine patients, or 11 per cent of the total number admitted, were retained in the hospital on that date. Thirty-six, or 14 per cent, had died in the hospital before that date. Thus, 194, or 75 per cent, were not in the hospital on the day of determination. As suggested earlier, a few of these had died on discharge, or left the area, thus removing themselves from the risk of return.

The retention rates for men and women at this point in time are identical, though a few more men than women had died in the hospital. There are large differences, however, in the subtotals for the different diagnostic groups. The group of Organic patients contributed 30 of the 36 deaths in

[5] E.g., Malzberg, Benjamin—*Cohort Studies of Mental Disease in New York State, 1943-1949* (National Association for Mental Health, 1958), p. 37, found a ratio of three males to one female in this category of "Alcoholic Psychoses."

TABLE 2.—*Number of patients on discharge status, retained in hospital, and died in hospital by October 16, 1961, tabulated by sex and diagnosis.*

		SCHIZOPHRENIC			ORGANIC			ALCOHOLIC			OTHER			TOTAL		
		M	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***
Patients on discharge status, October 16, 1961	N	40	47	**87**	15	5	**20**	32	5	**37**	19	31	**50**	106	88	**194**
	%	83	84	**84**	38	26	**34**	94	100	**95**	79	91	**86**	73	77	**75**
Patients retained in hospital, October 1961	N	6	8	**14**	6	2	**8**	2	0	**2**	2	3	**5**	16	13	**29**
	%	12	14	**13**	15	11	**14**	06	00	**05**	08	09	**09**	11	11	**11**
Patients died in Hospital by October 1961	N	2	1	**3**	18	12	**30**	0	0	**0**	3	0	**3**	23	13	**36**
	%	04	02	**03**	46	63	**52**	00	00	**00**	13	00	**05**	16	11	**14**
Total patients admitted, fiscal 1957	N	48	56	**104**	39	19	**58**	34	5	**39**	24	34	**58**	145	114	**259**

the hospital, accounting for 88 per eent of the deaths.

As mentioned earlier, there were many elderly patients in the Organic group, and inspection of the raw data shows that most of the deaths were in this elderly group. Not surprisingly, the Organic group had the smallest per cent discharged. At the other extreme, practically all of the Alcoholic patients were out of the hospital on the day of determination. The Schizophrenic and Other groups showed fairly similar, intermediate, distributions.

The situation presented in Table 2 could have eome about in different ways at different rates of speed, and leaves some important questions unanswered. One of these questions is how rapidly the discharges occurred. To answer this question, the amount of time in the hospital spent by each patient was computed by subtracting his admission date from his death or discharge date. It is then simple to tabulate the number of patients who died or were discharged during any given period of time after admission.

Table 3a presents such a tabulation for all the patients in the cohort, by two-month periods for the first six months, and by longer intervals after that. The first six columns show the number and per cent of patients who died during each period of time; the next six columns show the number and per eent discharged during each period; and the last six, obtained by subtraction, show the number and per cent continuously retained in the hospital at the end of each time period.

EARLY DISCHARGE FOR ONE-FOURTH

Thus, at the end of two months after their admission dates, seven patients (3 per cent) had died in the hospital, and 60 (23 per cent) had been diseharged. Still in the hospital at the end of their first two months were 192, or 74 per cent.

One year after first admission, 7 per cent had died and 74 per cent had been discharged, leaving only 19 per cent continuously retained for that entire year. During the next three years, another 7 per eent died and 7 per cent were discharged, to leave 6 per eent—16 patients—continuously retained without discharge.

Table 3a presents data on the entire cohort. Since there is good reason to believe that diagnosis is related to the timing of discharge, parellel data are presented for each diagnostic group separately in tables 3b, c, d, and e. To elarify the differenees in the diseharge and retention of these groups, the "per cent eontinuously retained" column from each table is also presented graphically in Figure 1.

At first glanee, it might seem that the differences in retention patterns of the diagnostic groups are not extensive, but actually, thcy are of considerable praetical importance. Since each curve in Fig. 1 represents the per cent of patients of that diagnosis still in the hospital at any given time, the *area under* the curve up to any point represents the eumulative total of "patient-years" in the hospital up to that time, per 100 admissions with the diagnosis in question.

TABLE 3-a.—*Hospital status (Number and Percent Died, Discharged, and Continuously Retained) of Cohort at the end points of successive periods of time in Hospital. Number: Males 145, Females 114, Total 259.*

PERIOD OF TIME IN HOSPITAL	STATUS IN HOSPITAL: DIED: CUMULATIVE						DISCHARGED: CUMULATIVE						CONTINUOUSLY RETAINED: CUMULATIVE					
	Number			*Percent*			*Number*			*Percent*			*Number*			*Percent*		
	M	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***
1 and 2 months	5	2	**7**	03	02	**03**	34	26	**60**	23	23	**23**	106	86	**192**	73	75	**74**
3 and 4 months	8	3	**11**	06	03	**04**	58	52	**110**	40	46	**42**	79	59	**138**	54	52	**53**
5 and 6 months	9	3	**12**	06	03	**05**	74	69	**143**	51	60	**55**	62	42	**104**	43	37	**40**
7 thru 12 months	13	4	**17**	09	04	**07**	99	92	**191**	68	81	**74**	33	18	**51**	23	16	**20**
13 thru 24 months	14	6	**20**	10	05	**08**	108	97	**205**	74	85	**79**	23	11	**34**	16	10	**13**
25 thru 48 months	22	10	**32**	15	09	**14**	111	100	**211**	77	88	**81**	12	4	**16**	08	04	**06**

TABLE 3-b.—*Hospital Status (Number and Percent Died, Discharged, and Continuously Retained) of Schizophrenic subgroup of Cohort at end points of successive periods of time in the Hospital. Males 48, Females 56, Total 104.*

PERIOD OF TIME IN HOSPITAL	STATUS IN HOSPITAL: DIED: CUMULATIVE						DISCHARGED: CUMULATIVE						CONTINUOUSLY RETAINED: CUMULATIVE					
	Number			*Percent*			*Number*			*Percent*			*Number*			*Percent*		
	M	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***
1 and 2 months	1	0	**1**	02	00	**01**	7	5	**12**	15	09	**12**	40	51	**91**	83	91	**87**
3 and 4 months	1	0	**1**	02	00	**01**	13	24	**37**	27	43	**36**	34	32	**66**	71	57	**63**
5 and 6 months	1	0	**1**	02	00	**01**	19	33	**52**	40	59	**50**	28	23	**51**	58	41	**49**
7 thru 12 months	1	0	**1**	02	00	**01**	35	49	**84**	75	88	**81**	12	7	**19**	25	12	**18**
13 thru 24 months	1	0	**1**	02	00	**01**	41	52	**93**	87	93	**89**	6	4	**10**	12	07	**10**
25 thru 48 months	1	0	**1**	02	00	**01**	42	54	**96**	89	96	**92**	5	2	**7**	10	04	**07**

TABLE 3-c.—*Hospital Status (Number and Percent Died, Discharged, and Continuously Retained) of Organic subgroup of Cohort at end points of successive periods of time in the Hospital. Males 39, Females 19, Total 58.*

PERIOD OF TIME IN HOSPITAL	STATUS IN HOSPITAL: DIED: CUMULATIVE						DISCHARGED: CUMULATIVE						CONTINUOUSLY RETAINED: CUMULATIVE					
	Number			*Percent*			*Number*			*Percent*			*Number*			*Percent*		
	M	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***
1 and 2 months	3	2	**5**	08	11	**09**	4	0	**4**	10	00	**07**	32	17	**49**	82	89	**84**
3 and 4 months	6	3	**9**	15	16	**16**	8	2	**10**	20	11	**17**	25	14	**39**	64	74	**67**
5 and 6 months	7	3	**10**	18	16	**17**	11	4	**15**	28	21	**26**	21	12	**33**	54	63	**57**
7 thru 12 months	10	4	**14**	26	21	**24**	14	7	**21**	36	37	**36**	15	8	**23**	38	42	**40**
13 thru 24 months	11	6	**17**	28	32	**29**	15	7	**22**	38	37	**38**	13	6	**19**	33	32	**33**
25 thru 48 months	18	10	**28**	46	53	**48**	16	8	**24**	41	42	**41**	05	1	**06**	13	05	**10**

TABLE 3-d.—*Hospital Status (Number and Percent Died, Discharged, and Continuously Retained) of Alcoholic subgroup of Cohort at end points of successive periods of time in the Hospital. Males 34, Females 5, Total 39.*

PERIOD OF TIME IN HOSPITAL	STATUS IN HOSPITAL: DIED: CUMULATIVE						DISCHARGED: CUMULATIVE						CONTINUOUSLY RETAINED: CUMULATIVE					
	Number			*Percent*			*Number*			*Percent*			*Number*			*Percent*		
	M	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***
1 and 2 months	0	0	**0**	00	00	**00**	17	4	**21**	50	80	**54**	17	1	**18**	50	20	**46**
3 and 4 months	0	0	**0**	00	00	**00**	23	4	**27**	68	80	**69**	11	1	**12**	32	20	**31**
5 and 6 months	0	0	**0**	00	00	**00**	28	5	**33**	82	100	**85**	6	0	**6**	18	00	**15**
7 thru 12 months	0	0	**0**	00	00	**00**	31	5	**36**	91	100	**92**	3	0	**3**	09	00	**08**
13 thru 24 months	0	0	**0**	00	00	**00**	32	5	**37**	94	100	**95**	2	0	**2**	06	00	**05**
25 thru 48 months	0	0	**0**	00	00	**00**	33	5	**38**	97	100	**97**	1	0	**1**	03	00	**03**

TABLE 3-e—*Hospital Status (Number and Percent Died, Discharged, and Continuously Retained) of Other subgroup of Cohort at end points of successive periods of time in the Hospital. Males 24, Females 34, Total 58.*

PERIOD OF TIME IN HOSPITAL	STATUS IN HOSPITAL: DIED: CUMULATIVE						DISCHARGED: CUMULATIVE						CONTINUOUSLY RETAINED: CUMULATIVE					
	Number			*Percent*			*Number*			*Percent*			*Number*			*Percent*		
	M	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***	*M*	*F*	***T***
1 and 2 months	1	0	**1**	04	00	**02**	6	17	**23**	25	50	**40**	17	17	**34**	71	50	**59**
3 and 4 months	1	0	**1**	04	00	**02**	14	22	**36**	58	65	**62**	9	12	**21**	37	35	**36**
5 and 6 months	1	0	**1**	04	00	**02**	16	27	**43**	67	79	**74**	7	7	**14**	29	21	**24**
7 thru 12 months	2	0	**2**	08	00	**03**	19	31	**50**	79	91	**86**	3	3	**6**	12	09	**10**
13 thru 24 months	2	0	**2**	08	00	**03**	20	33	**53**	83	97	**91**	2	1	**3**	08	03	**05**
25 thru 48 months	3	0	**3**	12	00	**05**	20	33	**53**	83	97	**91**	1	1	**2**	04	03	**03**

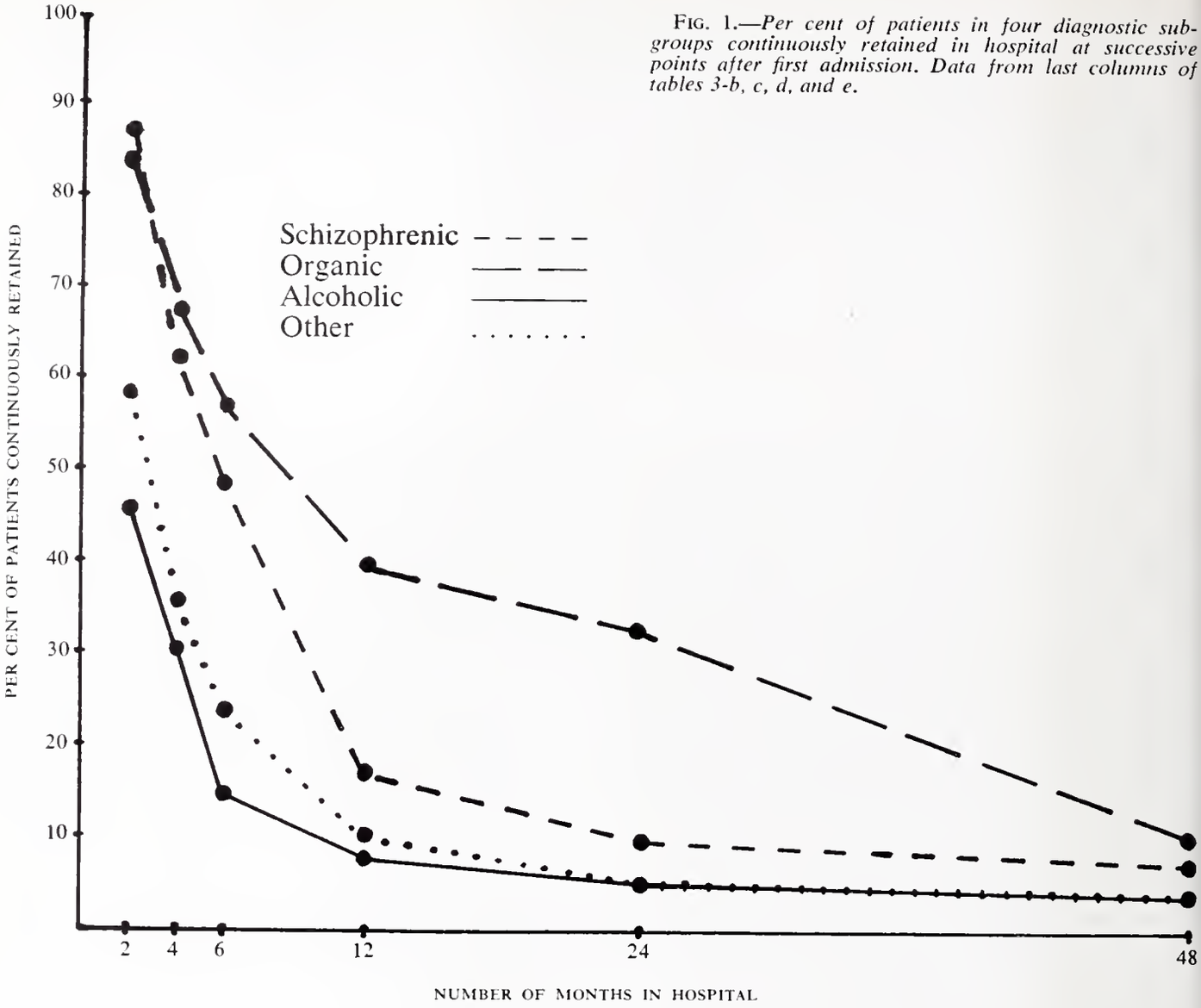


FIG. 1.—*Per cent of patients in four diagnostic subgroups continuously retained in hospital at successive points after first admission. Data from last columns of tables 3-b, c, d, and e.*

Using rough estimates of the areas shown in Fig. 1, in the four years shown there, 100 Organic patients would spend about 144 patient-years in the hospital. One hundred Schizophrenics would spend about 85, Alcoholics 35, and Others 50 patient years.

Thus, the impact on the hospital, in terms of beds, staff, and services needed by 100 Organic patients is much greater than an equal number of admissions from another group. In fact, based on the above estimates of patient-years spent by each group, 100 Organic patients would make the same demands on the hospital as 169 Schizophrenics, 415 Alcoholics, or 286 Other patients.[6] Thus, although it seems at first glance that the Organic and Schizophrenic patients only seem to lag behind the others, and eventually almost catch up, in fact, this "lag" increases tremendously the pressure on the hospital.

[6] This analysis does not consider the time spent in the hospital by *returned* patients, which, unfortunately, was not computed for this cohort. It does not seem likely, however, that consideration of the returned patients would substantially alter the relative standing of the four diagnostic groups.

As indicated, the above analyses have applied to patients *continuously* retained, without ever being discharged, and does not consider returned patients. It now remains to present the frequency of readmission or return to the hospital, and the later course of those returned. Table 4 shows that 34 per cent of all patients discharged were returned to the hospital as ill again at least once after their initial discharge. There do not seem to be extensive differences among the diagnostic groups, in frequency of return, but there is a striking sex difference with many more women returned than men. Considering Tables 2, 3a and 4 simultaneously, it is clear that men and women arrive at exactly the same figure of 11 per cent retained in the hospital in 1961 by different routes. Fewer men are discharged, and fewer returned; more women are discharged, but more return. Since this difference exists, roughly, in all diagnostic groups, it seems likely that it reflects a difference in philosophy of treatment between the male and female services of the hospital, with a greater risk-taking

TABLE 4.—*Patients returned to hospital after initial discharge.*

	SCHIZOPHRENIC			ORGANIC			ALCOHOLIC			OTHER			TOTAL		
	M	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*
Number of patients discharged by October 16, 1961	43	54	**97**	16	8	**24**	33	5	**38**	20	33	**53**	112	100	**212**
Number of discharged patients returned by October 16, 1961	12	26	**38**	4	6	**10**	8	2	**10**	5	10	**15**	29	44	**73**
Percent of discharged patients returned by October 16, 1961	28	48	**39**	25	75	**42**	24	40	**26**	25	30	**28**	26	44	**34**

TABLE 5.—*Status of returned patients, as of October 16, 1961.*

		SCHIZOPHRENIC			ORGANIC			ALCOHOLIC			OTHER			TOTAL		
		M	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*	*M*	*F*	*T*
Number of discharged patients returned by October 16, 1961		12	26	**38**	4	6	**10**	8	2	**10**	5	10	**15**	29	44	**73**
Returned patients redischarged by October 1961	N	9	19	**28**	3	3	**6**	7	2	**9**	4	8	**12**	23	32	**55**
	%	75	72	**74**	75	50	**60**	88	100	**90**	80	80	**80**	79	73	**75**
Returned patients retained in hospital October 1961	N	2	6	**8**	1	1	**2**	1	0	**1**	1	2	**3**	5	9	**14**
	%	17	23	**21**	25	17	**20**	12	00	**10**	20	20	**20**	17	20	**19**
Returned patients dying in hospital by October 1961	N	1	1	**2**	0	2	**2**	0	0	**0**	0	0	**0**	1	3	**4**
	%	08	04	**05**	00	33	**20**	00	00	**00**	00	00	**00**	03	07	**05**

TABLE 6.—*Proportion of patients returned from discharge according to length of stay in first admission.*

PERIOD OF TIME IN HOSPITAL	NUMBER DISCHARGED	NUMBER RETURNED	PERCENT RETURNED
2 months	60	14	23
Between 2 and 4 months	50	15	30
Between 4 and 6 months	33	16	48
Between 6 and 12 months	48	24	50

orientation in the latter. Unfortunately, the data were not gathered in a form that permits a complete investigation of this difference.

Table 5 presents the fate, as of October 16, 1961, of the portion of the cohort that was discharged and readmitted. Though four years is an adequate period of time in which to study discharges, it provides too short a time to permit the pattern of returns and redischarges to emerge clearly,[7] so a number of analyses of returning patients will be reserved for a later paper which will present findings on an older cohort. It is possible, however, to show, in Table 6, that patients who are discharged early are less likely to be returned than those who remain in the hospital longer after their first admission.

SUMMARY

This paper has tried to describe what happens to patients admitted for the first time to Hawaii State Hospital. The results hardly support the view of Kaneohe State Hospital as the "end of the line." The vast majority of patients admitted there are discharged, most within a few months. The majority of those discharged have remained out for four years, and even most of those readmitted are promptly redischarged. The chronic patient certainly exists, but apparently few of those who suffer one episode of serious mental illness will remain so seriously ill as to require continuous hospitalization. ■

ACKNOWLEDGMENT

The author wishes to thank William Cody, M.D., Robert Kemble, M.D., and Howard Gudeman, Ph.D., respectively Medical Director, Clinical Director, and Chief Psychologist at Hawaii State Hospital at the time this study was done, for providing encouragement and support for the study. Bernard L. Bloom, Ph.D., provided helpful criticism and suggestions for the analysis of the data. Mrs. Alethea Lum and the stenographic service of the hospital provided valuable help in abstracting and organizing the basic data from the hospital files.

[7] In spite of the shortness of time, 30 of the 73 returned and redischarged patients returned a second time; 16 of these returned a third time, two a fourth time, and one had returned five times before October, 1961.

Harbor General Hospital

". . . mental treatment and counseling are full-fledged, legitimate parts of general medical care."

Principles and Program of the AMA in Mental Health

MILLARD B. BETHEL, M.D.,* *Chicago, Illinois*

• *Every physician has a responsibility to help his patients understand and cope with emotional difficulties. The AMA October, 1962, held the first National Congress on Mental Illness and Health to promote this attitude and discuss ways of helping physicians to acquit themselves of this obligation. The Department of Mental Health of the AMA plans to provide consultation services where necessary, as well as advice on operational problems.*

A LITTLE more than a year ago, the AMA and its Council on Mental Health published two documents—the "AMA Statement of Principles on Mental Health" and the "Program of the Council on Mental Health." In these statements, the Council tried to delineate just how the AMA, the state societies, the local societies, and the individual physician can make significant and lasting contributions to the battle against mental illness. I quote from the Principles:

"Mental illness is America's most pressing and complex health problem. Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community, and the nation.

"The American Medical Association recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels —as a man of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques and much to contribute to the prevention, handling, and management of emotional disturbances. Furthermore, as a natural community leader, he is in an excellent position to work for and guide effective mental health programs." Parenthetically, natural leader he is, but how often does he exercise his full potential!

As you just heard, the AMA, and other informed people, consider mental illness "America's most pressing and complex health problem," but despite the problem's complexity, our program is based on optimism and not despair. Today, physicians know that they can successfully treat many forms of rather serious mental illness and that, with early diagnosis, cure rates are as good as those for physical disorders.

NEW DRUGS ARE KEY

The keys to the rapid progress we are making in the management of emotional disturbances are the new drugs and the treatment techniques which are at our disposal. We now measure treatment in terms of days, weeks, or months instead of years and decades. These medical advances also mean that the psychiatrist no longer stands alone—all physicians, regardless of specialty, have tools and knowledge enough to diagnose and manage many forms of mental illness. Nor have we yet really touched prevention's great potential.

This is one of the reasons why the AMA program places such considerable stress on the education of the physician in psychiatric principles—education for undergraduates, for house officers, and postgraduate work. And there is another facet to these educational endeavors. As the Council's program points out: "The understanding of the physician-patient relationship is modern psychiatry's major contribution to the education of the general practitioner and the specialist in fields other than psychiatry. With such insight, the doctor can make use of one of his most valuable tools —the *skillful employment of his personality* as an instrument of therapy."

In recent years, there have been many changes in undergraduate and graduate curricula. As a result, we find deservedly increasing emphasis on

* From the Department of Environmental Health, American Medical Association.

Presented at the 1st Mental Health Conference of the Hawaii Medical Association, June 25-26, 1963.

the principles of psychiatric medicine and the behavioral sciences. In many general hospitals, interns and residents are working with, and learning how to treat, the emotionally disturbed.

MD IS KEYSTONE

All of this is bringing a new look to medical practice today and, perhaps, an even different form to medicine in the future. But, in this broader picture, the physician still remains the principal member of the community health team. There are concomitant changes which should be made in the community health structure for maximal benefits to occur.

Let us hope that Hawaii has less than the mainland's dubious inheritance in the field of mental illness. By this I mean the decades of neglect, misinformation, and misunderstanding which have left deep and lasting scars on professional, public, and political attitudes toward the mentally ill.

For too many years, society has been willing, even eager, to delegate the prime responsibility for the care and treatment of the mentally ill to the state, and most of the states have done less than their duty. We are all too familiar with the overcrowded, understaffed, often degrading state institutions. It is not my intent to criticize, or disparage overmuch, the state hospitals. Their faults stem primarily from attitudes without rather than within.

COMMUNITY-CENTERED CARE

But fortunately attitudes are changing and we are beginning to hear the word "community" crop up with increasing frequency in discussions about mental illness and mental health. This *community* care concept was forcefully presented in the report of the Joint Commission on Mental Illness and Health. The AMA program also states that the *local community* must become the prime treatment resource for mental illness. On February 5 of this year, President Kennedy sent a special message to Congress dealing with the related problems of mental illness and mental retardation. The President asked that we return the care of the mentally ill to "the mainstreet of American medicine." In subsequent legislation, which the AMA supported, the Administration presented a plan for the construction, under a Hill-Burton type program, of comprehensive community mental health centers.

These facilities, locally controlled, would offer outpatient and inpatient services, diagnosis, treatment, rehabilitation and aftercare, and consultative services. They would also act as a focal point for community education programs. They would be open to all the physicians in the area served and would, at long last, allow the family physician to follow through on the treatment of his emotionally disturbed patients. These centers can also include day and night hospitals plus "walk-in" clinics for emergency psychiatric care.

PLANNING UNDERWAY

Statewide planning for this program is already underway and, obviously, if the bills pass Congress we are going to find ourselves right in the middle of a dynamic and growing program. Medical supervision and guidance is an essential element of the program. The time to prepare is now.

And even if these bills do not pass, we must still prepare. Federal help or not, we must make the local community the keystone in the fight against mental illness. Everything we have learned about emotional disturbances points to the fact that we can no longer shirk our responsibilities, we cannot shunt the mental patient off to a remote treatment center. The days of out of sight out of mind are going—the responsibility is ours and we must meet it.

"ALL OF US"

Let me say that I do not use the word "we" in any editorial sense. I mean *we,* all of us. There are no signposts delineating the boundaries of the mental health field. Quite the opposite is true and there are many different fields, specialties, and interests involved. Responsibilities must be shared and knowledge pooled if we are to achieve positive, dynamic programs.

Physicians are known to say that it is better to have a jealous wife than a jealous colleague. Mental health is too broad a field for interdisciplinary wrangling—there is more to do than all of us can straightway accomplish.

The fight against mental illness, demands a *team* effort. It demands mutual respect and understanding by all members of the team, each for the other.

There is still, for example, a communications gap between psychiatrists and other members of the profession. Often the nonpsychiatrists belittle their colleagues for talking "gobbledygook." To say the least, psychiatrists have developed a jargon of their own.

COMMON TONGUE NEEDED

It is high time we developed at least a common language. There is need for the internist, the GP, and the surgeon to know what their colleagues are talking about. Maybe the psychiatrist could take a short course in semantics and develop a less ethereal and more comprehensible dialect.

When happily the translators and annotators have finished, it will then be clearer that everyone

is concerned with the joys and sorrows of human beings, how and why they act and interact, how and why these actions are impaired; how inseparable are the psyche and the soma?

But language is only one barrier thwarting the physician's wholehearted entry into mental health. Another is the immense scope of the field. Along with medical influences, social, economic, and environmental factors play their parts in determining the mental health profile of our people. These may be strange new worlds for some physicians. There is so much to do, so many bricks to mold, and so little straw. Mental illness does hold us in a bondage not unlike that which confronted Moses and the children of Israel.

Obviously a physician cannot get involved with all the organizations working in his community. But his talent and knowledge would be invaluable to the most strategic group or groups.

PREVENTIVE APPROACH

Interest in mental health also adds a new dimension to the practice of preventive medicine. Who is in a better position than the family doctor to spot early signs of emotional disturbances in children; to recognize the potential alcoholic housewife or business man; to help remotivate the senior citizen lest he become disoriented in community life?

As the Council's program points out, there are many activities which can be carried out through the state and county medical societies and also through the Woman's Auxiliary. One vital project is the establishment of around-the-clock telephone service to dispense accurate information on the handling of psychiatric emergencies.

Others include informational programs on available referral services; training programs for volunteers; preparation and distribution of public education materials; setting up a mental health speakers bureau; the promotion of psychiatric services in the general hospital. Mental health career recruitment is a never-ending problem; encouraging worthwhile research must go on and on.

Aside from these promotional activities, the physician makes vitally important contributions to mental health in his everyday practice. He does yeoman service in merely clearing away many of the misconceptions and fears held by his patients. The question is, can he be induced to do even more?

STIGMA REMAINS

As doctors we know that mental illness is a disease, but too few laymen know it. Disease means something physically wrong. Brain tumors or strokes can produce behavioral changes which people will accept. Families will do everything possible to help the bedridden cancer patient. But, for many reasons, these same people lack understanding when mental illness is involved. Stigma still attaches to the sick mind; compassion is wanting for the aberrant mentality.

Every physician has the *responsibility* to help his patients understand and cope with emotional difficulties. He should not dare brush off their complaints with: "I can't find anything wrong with you. It's all in your head." He would do well, however, to make it clear from his attitude and actions that mental treatment and counseling are full-fledged, legitimate parts of general medical care. And if the problem is beyond his own competence he can, without fuss or loss of face, refer the patient to someone who will be able to help.

I have said, and I dare say others will reiterate, that every physician has an important role to play in this field. Mental health demands coordinated support from many different disciplines. Principal guidance must come from our profession, but we cannot be prosecutor, judge, and jury.

At the AMA's first National Congress on Mental Illness and Health October, 1962, approximately 2,000 persons met together in Chicago to discuss problems of common interest and to work out plans and programs for their particular states and regions. Hawaii was ably represented and we hope the meeting contributed something useful for this state.

AMA WILL ASSIST

The American Medical Association, especially through its Department of Mental Health, will do all it can to assist states in mapping out and implementing positive programs. In months and years to come, the Department of Mental Health plans to expand its activities and will be able to supply the states with a variety of aids. These will go beyond the pamphlet, how-to-do-it stage. It will include first-hand consultation services for those of you in state or local posts, with particular emphasis on operational problems. The more we do at home, the less Washington will be constrained to do. We at headquarters love to help, especially when it involves a trip to Honolulu, but the work must be done here.

The task you have set for yourself is immense. Mankind will never be free of mental illness, for on that day he would become as the gods; but he can strive for, and achieve, better mental health.

I invite your participation in a good, long, tough, hard fight to this laudable end. ■

Adolescent inpatients in Hawaii State Hospital have about a 50-50 chance of significant improvement.

Follow-up Study of Adolescent Patients Admitted to Hawaii State Hospital in 1957 and 1958

AUDREY W. MERTZ, M.D., *Kaneohe*

• *Of the 39 adolescent psychiatric patients first admitted to Hawaii State Hospital between January 1, 1957 and December 31, 1958, 21 were found to be significantly improved five years later.*

DURING THE past three years, staff members at Hawaii State Hospital have been developing a treatment course specifically suited to the needs of the adolescent patients.

Centered around an accredited intermediate and high school program, it includes social and recreational activities ranging from overnight camping to exchanging parties with a church young people's group. To help in assessing the long-range value of this enriched hospital life, a follow-up study was undertaken of young patients who came into the hospital just prior to this new program emphasis, i.e., 4½ to 6½ years ago.

In 1957 and 1958 the phenothiazine drugs were in wide use throughout Hawaii State Hospital, while insulin coma treatment was being used less. Electroshock treatment was still frequently employed. Through the influence of several of the teaching staff in psychiatry and psychology, came a new emphasis on group psychotherapy and on prolonged individual psychotherapy.

The establishment of the Convalescent Center for continued care and supervision of patients released from the hospital made it possible for group and individual psychotherapy to be continued, often by the same therapist, while the patient was adapting himself again to life at home. This group of patients, from 1957 and 1958, has also benefited from improved programs in community agencies and other state institutions, giving help outside the hospital.

STUDY METHOD

Thirty-nine patients between the ages of 12 and 17 were admitted to Hawaii State Hospital for the first time between January 1, 1957, and December 31, 1958. Three other children, aged 8, 9, and 11, were admitted because of severe behavior problems while awaiting placement at Waimano Home. These three are not included in the study.

Of the 39, four were still patients in Hawaii State Hospital on July 1, 1963. All four had had at least one trial out of the hospital on conditional discharge; no patient had to remain continuously after admission. All patients had help after leaving the hospital, through psychiatric or other facilities. Records of such contacts were reviewed and current assessments made by interview of patient, relatives, or therapist. From these data, a judgment was made by the author of "much improved," "improved," or "unimproved," to describe the patient's present status.

Psychiatric diagnosis is not precise, and comparative studies of patients grouped by diagnosis must be viewed with caution. The diagnoses used in this study are the official State Hospital diagnoses as recorded on the most recent admission by the doctor assigned to the case.

In almost every case, psychological testing was done at the hospital, or at the mental health clinic from which the patient was referred to the hospital. This evaluation was considered, as well as

case history and observation of the patient in the hospital, in arriving at the diagnosis.

SCHIZOPHRENIC CASES

Of the 39 patients, 22 were called schizophrenic of various types, or severely schizoid. Of these, three (14 per cent) are much improved, ten (45 per cent) improved, and nine (41 per cent) unimproved. Summaries of these patients are as follows:

Patient No. 1 was in Hawaii State Hospital for 13 months at age 16; diagnosis: schizophrenic reaction, acute undifferentiated type. She is a part-Hawaiian girl from Honolulu, the youngest of 12 children, and has a sister in Waimano Home. She remained in the hospital two months after birth for surgical repair of harelip and cleft palate. Through her childhood, she had help from the Bureau of Crippled Children and Public Health Nursing. Her mother died when she was five and she was subsequently cared for by her teenage sisters. The favorite child of her elderly father, a retired laborer, she was quiet, withdrawn, and sensitive about her facial deformity. Of low-average intelligence, she did school work up to her capacity and presented no behavior problems at school.

Her psychosis was of acute onset, with an abrupt change of behavior, but she was slow to improve in the hospital. Treatment included electroshock, phenothiazine, and Dexedrine, and group and individual psychotherapy. After discharge she continued in group therapy at the Convalescent Center and received help from Liliuokalani Trust and Division of Vocational Rehabilitation. She returned to school briefly and then worked in a cannery.

She is married to a skilled laborer and will soon move away from relatives into a better home. Condition: much improved.

Patient No. 2, in State Hospital for five months at age 15; schizophrenic reaction, acute undifferentiated type. She was a Caucasian-Hawaiian-Chinese girl, the fifth of eight siblings. Her father, a merchant seaman, was often away from home, and a poor provider. She was of bright average intelligence and did well at school, especially in athletics, music, and art. She had a poor relationship with her mother, and at age 14 reported her to the police for beating her up. A few months later, she ran away from home and was placed in the Detention Home. Later in the year, she was at The Queen's Hospital for one week because of confusion, truancy, and fighting with another girl. Individual psychotherapy was begun there and continued on an outpatient basis. During her stay in the State Hospital, she continued appointments with the same therapist and also for a half year after discharge, while she established herself in a foster home and returned to school. She is now married to a laborer and has three children. Condition: much improved.

Patient No. 3 entered State Hospital at age 16, stayed four months, and returned the following year for three months. Diagnosis: schizophrenic reaction, acute undifferentiated type. Patient is the second youngest of ten children of a Japanese family on Hawaii. Her parents ran a small business and had high ambitions for their children. Father had five children in his first marriage, remarried two years after his first wife's death and had five more children. Patient was considered bright and musically talented. Shortly after a close older sister married and moved away from the home, patient became acutely psychotic and was concerned about her relationship with a boy friend.

In the hospital, she was treated with shock and phenothiazine. She began individual psychotherapy which was continued by the same therapist for four years. After one unsuccessful attempt to return to school and a short rehospitalization, she did return to high school and graduated. She then took a business course at Kapiolani Technical School and has worked since as a clerk-typist. She recently married. Condition: much improved.

Patient No. 4, a Filipino boy, entered the State Hospital at 17 and remained four months. He returned the following year and stayed 16 months. Diagnosis: severe schizoid personality. His parents are aliens, his father employed on a Kauai sugar plantation. Patient is the older of two siblings, having a sister one year younger who has always been a better student and a more popular person than he. Because of withdrawal and school failure, he got help from a physician and from a public health nurse. He was treated in State Hospital with phenothiazine and group therapy. On his first return home, he did not return to school, was inactive, and threatened his family. On next return to Kauai, he was a psychiatric inpatient at Mahelona Hospital and from there has had a gradual rehabilitation. His parents have also had counseling. He is single and lives with his family. Condition: improved.

Patient No. 5, a Japanese boy born and raised in Hilo, Hawaii, entered the hospital at age 14 and remained 59 consecutive months before returning to his home. Diagnosis: schizoid personality, severe. He was the third of four siblings. The family are known to be inactive, quiet, reserved people. The homemaker mother is considered of dull intelligence, the laborer father a nervous person who had a stomach ulcer operation. The grandfather committed suicide at age 80 for reasons of ill health. Patient gradually withdrew from social contacts at age 13 and was in conflict with his next older sister. An older sister had been seen at the Mental Health Clinic for a similar withdrawal, from which she improved and went on to the University. Patient was always considered a bright boy, especially interested in art and in radios.

In the hospital, he had individual psychotherapy from a series of therapists and had phenothiazine drugs and electroshock treatment. He attended school in the hospital intermittently to the 11th grade level. He became more aggressive and masculine toward the end of his hospitalization and now at home is getting help from the Mental Health Clinic and the Division of Vocational Rehabilitation. Condition: improved.

Patient No. 6, a Hawaiian-Chinese-Filipino girl, first entered the hospital at age 15 and had six brief admissions during the next five years for a total of nine months in the hospital. Most recent diagnosis was schizophrenic reaction acute undifferentiated type. Patient was hanaied [given, by Hawaiian custom—ED.] to another family and legally adopted by them when she was one year old. This couple was divorced two years later and patient remained in custody of the adoptive mother, but was sent to Molokai to her paternal grandmother until age four, when this woman died. The family asked for help from the Welfare Department for placement, but then proceeded to shift the child around among relatives as they wished. The patient began showing behavior problems in school at age eight. During the next two years, she lived with her mother and Negro stepfather on the mainland and was molested by this man. After she witnessed her mother's promiscuity, patient hated her mother for this and for the mother's undermining of her relationship with a Negro aunt with whom she preferred to live. On return to Hawaii, patient resumed her contact with this aunt. Her mother and stepfather went back to the mainland for the next three years. The adoptive father has maintained an interest in patient but has seen her only intermittently. She had difficulty in school because of her many transfers. She was admitted to State Hospital at age 15, in the eighth grade, in an acute psychosis with suicidal behavior following a sex experience with a classmate.

In the hospital, patient had intensive individual psychotherapy which was continued through the next five years by the same therapist. She was given phenothiazine drugs. A foster home was found through the Juvenile Court and she won a scholarship to Kamehameha School. She did well until threatened by sexual interest from her foster brother-in-law. After several "runaways," she was sent to Salvation Army Girls' Home, but after running away

from there she was sent to Kawailoa Girls' Home. There she felt threatened by homosexual advances and asked for return to the State Hospital. However, she was soon returned to Kawailoa. In the past two years, she has been on parole. She lives in common law marriage with an ex–State Hospital patient. Despite considerable conflict and her ambivalence about marriage, this seems to be a stable relationship, and she has been involved in no further delinquencies. She left school at the 11th grade and has worked intermittently in the cannery and at waitress job. Condition: improved.

Patient No. 7, a Japanese boy from Hawaii, entered the hospital at age 17 and remained nine months. Diagnosis: schizophrenic reaction, paranoid type. His father worked for a construction company in Hilo until disabled by arthritis. His mother is ten years younger than his father. Patient was the fifth of seven siblings and was always considered a shy, withdrawn child. He has average intelligence, but his school grades began declining in the eighth grade and he dropped out of school at the tenth grade. He was employed as a field laborer. He was charged on two occasions with making obscene remarks to women and with grabbing a woman, and was seen by the visting psychiatrist at the Mental Health Clinic. Hospitalization was advised.

In the hospital he was treated with phenothiazines and group psychotherapy. He was a good worker in the kitchen. Since return home, he has not required further services of the Mental Health Clinic. Condition: improved.

Patient No. 8, a Japanese boy from Honolulu, entered the hospital at age 16 for 24 months and returned four months later for an additional 29 months. Diagnosis: schizophrenic reaction, schizo-affective type. Patient's father had an eighth-grade education and worked as a service station attendant. His mother, a strongly religious woman, was considered immature and dull and worked as a domestic. Patient is the oldest of three children. He was born with a congenital deformity of the left hand and had three finger stubs amputated at age five. Patient's mother felt guilty about this deformity, and there was never any discussion of it at home. Patient was very self-conscious about his hand and this led to dropping out of school at the sophomore year. He continued his newspaper route and wrote to girl pen pals, but became depressed, sullen, and withdrawn, and threatened hostile acts against his family. He was afraid of his father when the latter was drinking. He was evaluated and began treatment at the Mental Health Clinic but was asked to enter the State Hospital after setting fire to a building at his high school.

In the hospital he was treated with electroshock, insulin coma and phenothiazine. He also received treatment for a chronic neurodermatitis. He continued to be a very disturbed patient—suicidal, assaultive, trying to escape, and preoccupied with religious delusions. He had individual therapy by a series of therapists, group therapy, and pastoral counseling. His parents also received casework help. He is now continuing psychotherapy at the Convalescent Center and takes antidepressant drugs. He is working as assistant to his father in a custodial job. Condition: improved.

Patient No. 9 is a Hawaiian-Chinese-Caucasian girl who entered the hospital at age 14 and remained four months; diagnosis: schizophrenic reaction, acute undifferentiated type. The patient is the third of four siblings, born illegitimately after her parents divorced. Her father is a machinist. Patient wet the bed unitl age ten and began having difficulty in school from the seventh grade. She is of dull-normal intelligence. She began running away from home at age 14 and began using marijuana with some older anti-social people. She was sent to Kawailoa Girls' Home and transferred from there to the State Hospital because of depression and auditory hallucinations encouraging suicide. Patient's mother was quite overprotective of her, demanding of the hospital staff, and very evasive about giving family information.

Patient received shock treatment and phenothiazine, and was returned to Kawailoa. From there she was placed in a foster home for one year and continued her schooling to the tenth grade. She then ran away again, and was living with homosexual girls and taking barbiturates. She worked as a waitress. When found, she was sent again to Kawailoa for a year, and then was trained and employed as a power machine operator. She is living at home now and coping better with the pathological relationship with her mother. Condition: improved.

Patient No. 10 was in the State Hospital for four months at age 16 and diagnosed schizophrenic reaction, acute undifferentiated type. His father was a Chinese-Hawaiian skilled laborer, who had married three times. His mother was a lei seller and a practical nurse who had three marriages; she had a drinking problem. Patient is the youngest of their three sons. He was considered spoiled by his mother, mischievous, hot tempered, and demanding. He was in trouble at school from the sixth grade and his parents sent him to the Dentention Home as incorrigible. After his parents separated, he stayed with his father and step-sister. He was seen at the Mental Health Clinic after an acute onset of disturbed behavior in the tenth grade. He was admitted to the State Hospital, where he had phenothiazine treatment. He had follow-up help at the Convalescent Center, moved to his mother's home and returned to high school. He has since been in the National Guard and is married. His brother entered the State Hospital a year after patient's discharge and has continued to be incapacitated, with the diagnosis of hebephrenic schizophrenia. Condition of Patient No. 10: improved.

Patient No. 11 was in the State Hospital for three months at age 12 for schizophrenic reaction, acute undifferentiated type. She is the oldest of four children of a Caucasian family that moved to Hawaii shortly before her admission. Her father is a professional man and the family is striving for a social position. The family consulted a psychiatrist about their daughter when she was three years old and attending a nursery school. They considered her good at singing, dancing, and reciting, but worried that she was not affectionate. Through the years, the family set standards beyond her ability, and the mother was especially concerned about the child's sexual interest.

Patient had an abrupt onset of psychosis at puberty centering around sexual problems. She was treated at The Queen's Hospital for one week and sent to the State Hospital. She had phenothiazine and psychotherapy which was continued at the Convalescent Center after she was discharged. She had home tutoring and later retured to regular school attendance. The parents were involved in social casework during patient's time in the hospital and for the following year. They then preferred to get services from St. Francis Mental Health Clinic, where they have had continued treatment for several years. Condition: improved.

Patient No. 12 was in the State Hospital for three months at age 16, for schizophrenic reaction, catatonic type. Patient is a Portuguese girl from Honolulu, the third of eight siblings. The parents divorced when she was small but lived together later without remarriage. The father died when patient was 12, and mother lived in a common-law relationship with a man the patient disliked. The family had Welfare help. Both to this agency and to the hospital staff, mother was unwilling to give personal information.

Patient had acute onset of psychosis at the same time she had a mastitis. Because of her refusal to eat, she had tube feeding in the hospital. She had psychotherapy which was continued at the Convalescent Center after her discharge. She returned to high school and graduated. She then married a skilled laborer and planned to move to the mainland. Since she could not be located at this time, she is presumed to be out of the State. Condition: improved.

Patient No. 13 was in Hawaii State Hospital for six months at age 17. He had come to Honolulu from the Philippine Islands just prior to his mental illness. His father had emigrated to Hawaii for a sugar plantation job, leaving his mother pregnant and with two small sons.

Patient was his mother's favorite as the oldest boy. The mother died of heart disease and tuberculosis when patient was 11 and the children were sent to paternal relatives. His father married a Caucasian woman in Hawaii who already had four children. They had one son of their own at the time the stepmother went to the Philippine Islands to get the three older children. Patient was considered shy, fearful, and effeminate, and had difficulty in adjusting to high school here. He refused to talk or eat and was treated in The Queen's Hospital with shock treatment. At this time, there was considerable conflict in the family over money, crowded living conditions and conflict between patient's father and the 18 year old stepson. The stepmother then took an overdose of insulin in a suicide attempt and inflicted serious brain damage on herself.

While patient was in the State Hospital, he had shock treatment and was in group psychotherapy and casework. The family got help from the Welfare Department and public health nurses because of the multiple problems. Patient returned to high school and had help from the school counselor. He did well academically and socially, got a part-time job, and later went to the mainland for a year as a restaurant worker. He returned to Hawaii after his stepmother's death and is living with his father. He was turned down by the service, but has continued to hold a job at a restaurant. Condition: improved.

Patient No. 14, a Japanese girl, entered the hospital at 16 and is now in the hospital for the fourth time for a total of 46 months' hospitalization. Diagnosis: schizophrenic reaction, schizo-affective type. She is the seventh of nine children of a rural Oahu family. Two brothers have also been psychotic. She was a bright student, extroverted and ambitious. Her teachers noted withdrawal and preoccupation when she was fifteen years old and her brother had just been admitted to the State Hospital. She was helped by school social workers before and between hospital admissions. She has often been depressed and made one serious suicide attempt. She has been treated with shock, phenothiazines, and intensive prolonged individual psychotherapy with one therapist. She completed high school but has been unable to hold a job and form satisfactory stable relationships with other people. Condition: unimproved.

Patient No. 15, a Chinese boy, was admitted to State Hospital at age 17 and remained seven months. Diagnosis: schizophrenic reaction, simple type. Patient's father, 16 years older than his mother, divorced her when patient was three because she became pregnant by a Caucasian soldier. His mother has since married twice and works as a waitress. His father became a merchant seaman after the divorce. Patient and his sister, two years older, were cared for by their paternal grandmother. A single aunt and uncle also stay in this household. When his sister became rebellious at age 13, she was sent to live with her mother. Patient missed her company and visited her frequently at their mother's home. His sister, always more aggressive and successful than the patient, completed school and married. School teachers became concerned about patient from the fourth grade because he was withdrawn and quiet. Father could not see any problem, considering patient to be like himself. Patient attended school through the tenth grade but was always alone, late to class, and silent except when directly questioned.

Hospitalization was advised by the Mental Health Clinic because of gradual prolonged social deterioration. In the hospital he was given shock treatment and phenothiazine. After leaving the hospital, he had supportive help from the Convalescent Center, the Division of Vocational Rehabilitation and the Child and Family Service. He completed a course at a technical school, but has been unable to hold a job. He maintains a tenuous contact with his psychiatrist, but continues to be a very lonely and unproductive person. Condition: unimproved.

Patient No. 16, a Japanese boy from Oahu, entered the hospital at age 17 for ten months and returned four years later for six months. Diagnosis: schizophrenic reaction, paranoid type. His father was born in Japan and after coming to Hawaii, tried driving a taxi, raising bananas, and working as a janitor. His mother, born in Hawaii, had a sixth grade education and worked as a hotel maid. She is considered aggressive, short-tempered, and dominant. They lived in a common-law arrangement for two years because her family opposed the marriage. They adopted a girl after several childless years and then had the patient and three younger girls of their own. He began truanting from school at the ninth grade and dropped out at age 15. At that time, his parents referred him to the Juvenile Court as incorrigible since they were unable to control him. He had private psychiatric treatment at The Queen's the following year and then got help at the Catholic Social Service. Later he had to be sent to State Hospital despite family reluctance.

In the hospital, he received shock treatment, phenothiazine, and casework. Group and individual psychotherapy begun at the hospital were continued after discharge, at the Convalescent Center. He got help from Division of Vocational Rehabiltation and worked in various laboring jobs. Because of drinking, stealing and irresponsible behavior, he was sent away from home by his parents. He went back to Catholic Social Service for more help and returned to high school in the eleventh grade. He was readmitted to the hospital after hitting his vocacational counselor, who had tried to discourage his ambition to be an artist. During his second hospitalization, he again received shock treatment and phenothiazine, and is now attending the day hospital at the Convalescent Center. He is unemployed and continues to be impulsive and irresponsible. Condition: unimproved.

Patient No. 17 entered the State Hospital at age 14 and remained 15 months; diagnosis: schizophrenic reaction, catatonic type. He is a Hawaiian-Filipino-Caucasian boy, the third of three siblings. His father was born in the Philippine Islands and works as a laborer. His parents were divorced when he was 1½ years old, and his father continued to live in the home as a boarder. His mother remarried a skilled laborer. The mother now has 10 children. He was jealous of the younger half-siblings, was very demanding of money from his father and stepfather and often truanted from school to hang around home. He was always shy and withdrawn at school and was referred to the Mental Health Clinic for evaluation at age 11. He was found to be mildly mentally retarded and was sent to Ala Moana School. His older sister is also mentally retarded. For some months after the boy dropped out of school, the family delayed making a decision about the recommendation to send him to State Hospital.

In the hospital, patient received phenothiazine, methylphenidate, and electroshock treatment. He was in group therapy and had special help in occupational therapy. The family was involved in casework, and many home visits were made. After discharge, he received home tutoring and continued casework but both were dropped because of the lack of interest from patient and his family. He refused attendance at the day hospital at the Convalescent Center and missed appointments at the Division of Vocational Rehabilitation. He has been unwilling to look for work and was dropped after a three-day trial period in the pineapple fields. The family now considers him to be without mental illness because he is not aggressive. Condition: unimproved.

Patient No. 18 had two admissions to the State Hospital at age 16 and at age 19 for a total of 19 months. Diagnosis: schizophrenic reaction, paranoid type. He is part-Hawaiian, from Oahu. He and his younger brother were born out of wedlock and continued in foster home placements after the mother married. Patient was sent from the foster home to the Salvation Army Home where he stayed from age 9 to 14. He was then sent to Koolau Boys' Home because of 20 charges of burglary, car theft, and runaway. He presented behavior problems at school throughout his childhood, and was noted as extremely aggressive and prone to molest animals in a sadistic manner. At the Mental Health Clinic, he was found to have borderline defective intelligence.

He was transferred from Koolau to the State Hospital because of overt psychosis and was treated with shock treatment and phenothiazine. He was returned to Koolau after three months. When he was later sent out on parole,

he was caught for car theft within a week. On the next attempted parole he did the same thing and was sent to jail when apprehended. From there he was sent back to the State Hospital because of psychosis. Attempts to involve him in the hospital school program were unsuccessful because of his low ability and lack of interest. He had to be kept on the maximum security ward because of his turbulence and repeated efforts to run away.

When later returned to Koolau, he made several escapes from there. At age 20, he was released from parole and took employment on a fishing boat. Condition: unimproved.

Patient No. 19 entered the State Hospital at age 12 and remained two years. When a trial period at home was unsuccessful, she returned seven months later, and has remained continuously since for a total of 71 months. Diagnosis: schizophrenic reaction, catatonic type. Patient is Filipino-Hawaiian, the youngest of seven siblings. At age three, she witnessed her father's fatal stabbing of her mother and himself. The children were split up and sent to various foster homes. Patient was adopted by an elderly, illiterate, childless couple who were her godparents. Throughout her school years, she was quiet, withdrawn, and a slow learner. She became psychotic at puberty, threatened her adoptive parents with a knife and believed she was already dead.

In the hospital, she has had shock treatment and phenothiazine. In early adolescence, she was seclusive and had hallucinations and bizarre ideas. She became explosive and combative when annoyed and was especially fearful of men. She has gradually become more able to participate in the adolescent treatment program at the hospital and has developed some artistic interests and social skills. She remains unable to form close relationships, but welcomes friendship, from staff and volunteers, if little is expected of her in return. Condition: unimproved.

Patient No. 20 was in the State Hospital for 14 months at age 17; diagnosis: schizophrenic reaction, chronic undifferentiated type. She is a Chinese-Portuguese girl from Hawaii, raised on a plantation. Her maternal grandmother, maternal uncle, and sister have all been State Hospital patients. She is the youngest of four girls, and considered her mother's favorite. Her father died at age 40 when patient was 1½ years old. A bachelor uncle living in the home has been arrested for voyeurism. Patient was always shy and withdrawn, and was teased as "crazy" throughout her school years. She made average grades until she dropped out from the tenth grade. She was referred to the Hawaii Mental Health Service at age 13 because of peculiar stomach and eye pains and hallucinations. Her sister had been admitted to the State Hospital just prior to that time. Her mother was very reluctant to part with her when hospitalization was recommended, but did agree to it when patient's disturbance became acute and unmanageable.

Electroencephalogram at the State Hospital was normal. She had shock treatment and phenothiazine. After return home, she had follow-up psychiatric supervision with continuation of her medication. She refused to go out of the house and did little at home, but her mother made no complaints about her. She is considered to be chronically psychotic and unimproved.

Patient No. 21 entered the State Hospital at age 17 and remained eight months. After a year at home, she was returned to the hospital and has remained since for a total now of 42 months. Diagnosis: schizophrenic reaction, hebephrenic type. Patient is Japanese, the tenth of 11 children of a plantation family on Oahu. The patient was the youngest in the family until her brother was born when she was six years old. She felt displaced, lonely, and resentful. She had been considered by the family to be of "weak mind" throughout childhood, in that she showed no initiative, was sloppy and peculiar. She went with a Caucasian Marine for about a year, expected to marry him, and became psychotic when this relationship ended. She graduated from high school, but never found employment. She was treated in The Queen's Hospital and then committed to the State Hospital. She has received phenothiazine drugs. It has been difficult to involve her in hospital programs, and she remains bizarre, silly, and preoccupied with sexual thoughts. Condition: unimproved.

Patient No. 22 entered the State Hospital first at age 17 and has had four admissions for a total of 22 months; diagnosis: schizophrenic reaction, chronic undifferentiated type. This is a Japanese boy from Honolulu, the older of two brothers. Two maternal uncles have been in the State Hospital and another maternal uncle killed himself. Following patient's hospitalization, his mother had a psychosis for which she got private treatment. Patient's father worked as a waiter and his mother as a sales clerk.

Patient had febrile convulsions in early childhood. Throughout his school years he did poor work and presented a behavior problem. He began voyeurism at age 15 and has repeatedly been in trouble for this. He sought help from a minister and had some private psychiatric treatment. He was seen at the Mental Health Clinic where hospitalization was advised for incipient schizophrenia. At about the same time, his younger brother was involved in larcenies and burglaries.

In State Hospital, patient had individual psychotherapy which was continued in and out of the hospital for several years by the same therapist. His parents had casework at the hospital, and then at the Child and Family Service. Patient had follow-up services at the Convalescent Center, but was always difficult to help and control. He returned to high school and held various jobs briefly. He got some help from the Division of Vocational Rehabilitation. He was in jail for six months for vagrancy after again being caught peeping. After release from jail, he was soon caught at the same offense and sent back into the hospital. Condition: unimproved.

SOCIOPATHIC CASES

Seven patients were called sociopathic. Two of these (29 per cent) were improved and five (71 per cent) unimproved.

Patient No. 23 entered the State Hospital from the Koolau Boys' Home at age 16 and remained three months; diagnosis: sociopathic personality, antisocial type. He was the illegitimate child of a Japanese woman and a Caucasian man, and was raised on Oahu by his maternal grandmother, a friend, and maid. He attended nursery school from age three while his mother worked as a store clerk. His mother married a man 11 years her senior when patient was six, and he has three younger half-siblings. He had the advantages of private schooling and participation in a church young people's group and explorer's scouting and later had private psychiatric treatment. He got average grades and poor character ratings throughout his school years and had to repeat the 9th grade. He was charged with burglaries and assault and battery, and made several suicide attempts.

During his period of observation at the State Hospital, he ran away to avoid return to Koolau, and was apprehended for stealing cars. Later, on parole, he went to technical school, committed more burglaries, and ran away to the mainland to avoid arrest. He was there arrested for speeding and stealing cars, and was in a Federal correctional institution until age 21. He has since returned to Hawaii, is married, and holding a job in a service station. Condition: improved.

Patient No. 24 was in Hawaii State Hospital for two months at age 14; diagnosis: sociopathic personality, antisocial type with psychotic features. He is Caucasian-Samoan, the oldest of six siblings, and lived in Samoa until the family moved to Hawaii when he was eight years old. His father was in the Navy and was also a pastor of a church when he was at home. His upbringing was characterized by overindulgence, alternated with rough discipline, especially from his father. A sister died in a car accident when patient was seven and his mother died of a heart attack when he was 13. Patient grieved a long time after his mother's death.

Patient was involved in minor offenses at Naval Housing at age 10. He was referred to the Mental Health Clinic for evaluation at age 13 because of declining school achievement. Retesting the following year revealed schizophrenic thinking disturbance. This was about the time his father remarried a younger woman. The patient attacked a man with a knife and was sent to Koolau Boys' Home. From there he was transferred to State Hospital, and received phenothiazine and methylphenidate. He was considered dangerous and was returned to Koolau where he could get stricter discipline and closer control.

On parole, he got involved in a minor offense on Naval property and was sent back to Samoa. From there he joined the Marines under a false name. After his tour of duty, he returned to high school on Oahu and was supervised by the Parole Office. He is interested in sports and body building and has shown no further tendencies to violence. Condition: improved.

Patient No. 25 entered State Hospital at age 14 and remained two months. Diagnosis: sociopathic personality, sexual deviation with depression. This Chinese-Hawaiian-Caucasian boy has lived on Molokai and Oahu, and is the second of two siblings, having a sister 12 years older. His father's family opposed the marriage of their son to a woman of different race six years older than he. The father remained in residence with his own parents, helping in their store, seldom visiting his wife and children. Patient was raised by his mother, sister, and aunt, and began homosexual contacts at age nine. He became restless, nervous, and sleepless from age 10, preoccupied with sex fantasies, and worried about family finances. He was taken to a kahuna. He had to repeat the fifth grade. The following year he had private psychiatric treatment at The Queen's Hospital for depression.

In the State Hospital, he received individual psychotherapy and phenothiazine. He continued his psychotherapy at Convalescent Center, living for a few months with his aunt. He returned to school, then dropped out, keeping up with home tutoring. He later returned to school, and finished high school. He was dropped from a junior college in his first year. He continues as an active homosexual and an unstable person. Condition: unimproved.

Patient No. 26, a Hawaiian-Portuguese-Caucasian girl from Honolulu, was admitted to the hospital at age 13 and remained one month. Two years later she returned for two months. Diagnosis: sociopathic personality, antisocial type. Patient was deserted at age two months by her natural mother, and a foster home was found for her by the Catholic Social Service. Her father interfered with this placement, and took the baby to his brother and alcoholic sister-in-law. At age four she returned to live with her father and Japanese stepmother. The stepmother had lost custody of her prior stepchildren and was eager to do well with this stepchild. She was raised as an only child. Her school grades declined in the seventh grade, and she presented behavior problems at school from the eighth grade. She had an episode of probable hysterical paralysis. She was restless and hostile at school, especially before her menstrual period, and frequently ran away. She had a brief visit from her natural mother when she was about 11.

In the hospital, she had intensive psychotherapy, which was continued by the same therapist over the next two years. She was sent to Kawailoa Girls' Home because of continued misbehavior, including larceny. She has been on parole for four years and has not had to return to Kawailoa, but is considered to be making poor progress. She dropped out of school at the sophomore level, has been living at home and is unable to hold a job. She continues to be promiscuous with men and also closely attached to a homosexual girl. Condition: unimproved.

Patient No. 27 was in State Hospital for one month at age 16; diagnosis: sociopathic personality. He is Puerto Rican, the fourth of five children born in his mother's second marriage. He lived on Maui until the family moved to Honolulu when he was three years old. His parents' marriage deteriorated during the time his mother was pregnant with him. The parents were divorced when he was four years old, and his mother took the children. From the seventh grade, he became defiant at school, smoking and gambling on the school grounds. He ran away from home and became involved in burglaries. He was referred to the Mental Health Clinic and was considered for the Kalakaua School Project, but turned down because of "too much explosive anxiety." He was sent to Koolau Boys' Home, where his two older brothers had already been sent. He was transferred to the State Hospital from Koolau because of a suicide attempt, following rejection by his girl friend. In the hospital, he received shock treatment and phenothiazines. He escaped with the intention of killing himself and his girl friend. One week after, he was sent back to Koolau. He did poorly on parole and was later sent to the State Prison for three years for burglary, car theft, and assault and battery. Condition: unimproved.

Patient No. 28 was in the hospital for two short admissions at age 15; diagnosis: sociopathic personality, antisocial type with depressive elements. He is a Filipino-Chinese-Hawaiian boy from Oahu, the second of four siblings. The father, a taxi driver, gambled and was abusive to his wife. His mother worked at a cannery and as a domestic, so the children were often with babysitters. The family had Welfare help with casework because of the immaturity of the parents and the many social problems of the family. Patient was severely punished by his father and was frequently involved in stealing and "runaways." He was referred to the Mental Health Clinic and was in the Salvation Army Home from age 10 to 12. Because of continued runaways and burglary and larceny offenses, he was sent to Koolau Boys' Home. From there he was admitted to the State Hospital twice following suicidal attempts. In the hospital, he received phenothiazine drugs. He was returned to Koolau and later paroled. He then became involved in a car theft, burglary, and assault and battery for which he was sent to Oahu Prison. Condition: unimproved.

Patient No. 29 came into the hosptial for two months at age 15; diagnosis: sociopathic personality, antisocial type. A Caucasian boy from the mainland, his father is an engineer, his mother a teacher. He is the only child. His father was in the service during his early years. The parents divorced when patient was six. Because of the mother's employment, the patient was in foster homes and in nursery school. He was considered hyperactive and aloof, possibly deaf when he was a small child. According to his mother, he had a "nervous breakdown with paralysis" at age 6.

He was evaluated at the Mental Health Clinic at age seven and had Dilantin and phenobarbital because of abnormalities on the electroencephalogram. He became involved in delinquencies, and was known to the Juvenile Court from age 13. He had private treatment from three psychiatrists in succession. Voluntary admission to the State Hospital was advised, because previous attempts at helping him at the Koolau Boy' Home and a foster home had been unsuccessful. He has continued to be involved in delinquencies and has recently been in jail. Condition: unimproved.

ADJUSTMENT REACTION

One patient, diagnosed as having an adjustment reaction of adolescence, was found to be much improved.

Patient No. 30, a Portuguese-Caucasian girl from Oahu, entered the State Hospital at age 15 and had four brief admissions during the subsequent year for a total of seven months in the hospital; diagnosis: adjustment reaction of adolescence. She is the oldest of three siblings, having two younger brothers. Her father deserted the family when patient was five; her mother married a Negro man and had three more boys. Patient often stayed with her grandmother. Her stepgrandfather molested her at age six. She was also sexually molested by a sailor boy friend of her mother and by her Negro stepfather. She

began drinking, with her mother's encouragement, at age 12. She received some help from her high school counselor after confiding about her home life. From age 14, she frequently ran away and made suicide attempts by cutting her wrist. She stayed briefly at Salvation Army Girls' Home before admission to Queen's following another suicide attempt.

At the State Hospital she began intensive psychotherapy, which was continued by the same therapist in the next three years during a brief stay in a foster home and then at Kawailoa Girls Home. She was later paroled to a foster home, and got help from the Division of Vocational Rehabilitation after graduating from high school. She is now married, has a child and has settled down. Condition: much improved.

ORGANIC CASES

Organic cases totalled nine, with one (12 per cent) much improved, four (44 per cent) improved, and four (44 per cent) unimproved. Cases follow:

Patient No. 31 entered the State Hospital from Kauai at age 16 and remained three months. Diagnosis: acute brain syndrome, associated with intracranial infection, with catatonic features. The patient is the youngest of six siblings of a Filipino plantation family. At age 16, in the tenth grade, he had an upper respiratory infection with gastroenteritis followed by insomnia, confusion and aggressive, negativistic behavior. After a fight with a bus driver, he was admitted to Waimea Hospital and from there to the State Hospital. In the State Hospital, an electroencephalogram showed a seizure disorder. Pneumoencephalogram was normal, as was a spinal tap, and he was considered to have a viral encephalitis. He received testosterone, cortisone, thyroid, Dilantin, and phenobarbital. Since he was apathetic and unresponsive, and refused food, electroshock treatment was given.

He was returned home to continue his convalescence and had a slow, steady improvement in his physical symptoms. He returned to a light schedule at school, but dropped out because it was too difficult for him. He then did summer work on the plantation and took a course in welding at the Kauai Technical School. At present, he is single, living with his family and working for the plantation as a laborer. Condition: much improved.

Patient No. 32 entered State Hospital at age 17 for nine days, returned the following year for one month. Diagnosis: chronic brain syndrome with convulsive disorder and behavioral reaction. This Filipino boy was raised on a sugar plantation on Hawaii, later moved with his family to Oahu. He is the youngest of five siblings of his mother's second marriage. His father was mean, once chasing his stepdaughter with a cane knife. Both stepdaughters ran away from home and one was placed at the Salvation Army Girls' Home. He was close to an older brother, and grieved at his death in a car accident when patient was 14. He was then protective of his widowed sister-in-law when she was abused by her new husband. Medical history included chest surgery for bronchiectasis and hospitalization at age 13 after being hit in the right temple by a spent bullet. At age 17, after being beaten about the head in a fight with other boys, he began having attacks of confusion and automatic assaultive behavior. Previously he had been considered good natured, mild mannered, and well liked. Because the family is superstitious, they did not accept medical recommendations for treatment of this epileptic condition and reluctantly agreed to State hospitalization.

Electroencephalogram showed abnormal spike forms in the right parietal region compatible with psychomotor epilepsy. He was treated with Dilantin and phenobarbital, and cooperated for a while with follow-up at the Epilepsy Clinic. Because of a later suicide attempt and continued temper outbursts, especially when drinking, commitment was processed for Waimano Home as an epileptic; however, the family evaded this commitment and patient continued his employment as a delivery boy or car washer. The family was lost to follow-up in 1960 and are no longer in the Honolulu directory. No inquiries about him have been received from other institutions. It is assumed that he is self-supporting, and his condition is considered improved.

Patient No. 33, a Filipina girl, came in to the State Hospital at age 16 and remained 28 months. Diagnosis: moderate mental deficiency and hebephrenic schizophrenia. She is the third of five siblings and was born one month overdue after prolonged labor. Her father is in the Army on Oahu. She was always considered a timid, quiet, retarded child. She repeated two grades in school and then was dropped after the eighth grade. She was left to do the housework and was alone all day while her parents worked.

With the onset of psychosis, she was treated at Tripler for three months with shock treatment and phenothiazine. In the State Hospital, she received shock treatment, phenothiazine, and methylphenidate, but was too defective in intelligence to benefit from active treatment programs in the hospital. Waimano placement was recommended, but not accepted by the family. She is now at home and supervised by a married sister. The family considered her returned to her prepsychotic level, and her condition is considered improved.

Patient No. 34, a Filipino boy reared in Honolulu, entered State Hospital at 17 for four months. Diagnosis: chronic brain syndrome associated with convulsive disorder, with psychotic reaction and moderate mental deficiency. His father, a laundry worker, died of tuberculosis when patient was four. Mother remarried, and patient has four younger half-siblings as well as three older siblings. He first had convulsions at six months, and received care from the Bureau of Crippled Children from age six. A pneumoencephalogram showed agenesis of the right cerebral hemisphere. He attended classes for the mentally retarded and received anticonvulsant medication.

Because of disturbed behavior, admission to State Hospital was necessary. He continued on anticonvulsants and had physiotherapy. After leaving the hospital, he was followed at Epilepsy Clinic, at the Lanakila Craft Center under the Division of Vocational Rehabilitation, and in the Health Department's Mental Retardation day program, and had visits by a public health nurse. His medication was discontinued and he had no further seizures. He was dropped from these various supportive programs because of his good adjustment and he has maintained employment as a busboy. He is single and lives with his family. Condition: improved.

Patient No. 35, a Japanese boy from rural Oahu, entered the hospital at age 16 and remained 17 months. Diagnosis: chronic brain syndrome associated with trauma with right-sided hemiparesis and psychotic reaction. Patient is the oldest of four children of a sugar plantation family. Showing behavior problems at school and dropping out at the 10th grade, he worked on a sampan as a fisherman. He injured himself while driving the family car and was unconscious one month. He was helped at the Rehabilitation Center with services of Bureau of Crippled Children, Division of Vocational Rehabilitation, and Public Health Nursing. Since he could not be cared for at home, he was admitted to the State Hospital. Psychological testing showed that his intelligence had been lowered to the mentally retarded trainable level. He received occupational therapy and physiotherapy. After discharge, he was again in the Rehabilitation Center for a time and then was discharged home. He has had further services from the Convalescent Center. He was able to make a trip to the mainland with his parents and has adjusted satisfactorily at home. Condition: improved.

Patient No. 36, a Portuguese boy, entered the State Hospital at age 14 for one month; diagnosis: acute brain syndrome, associated with convulsive disorder. Patient was born in his mother's second marriage and he has two older half-brothers. Mother divorced and remarried, and so he was raised by a stepfather on Oahu. He began having convulsions at age eight and was suspended from

school in the fourth grade because of uncontrollable behavior. He was in Waimano Home for six months at age 13.

Because of rages ending in suicide attempts, he had admissions to The Queen's Hospital and the Hawaii State Hospital while awaiting return to Waimano Home. He was maintained on anticonvulsant drugs. Electroencephalogram showed a generalized abnormal record with slow wave focus in the right temporal area compatible with psychomotor epilepsy. He was later released from the Waimano Home to live with his father on the mainland. He continues to show behavior problems. Condition: unimproved.

Patient No. 37 entered the State Hospital for one month at age 12; diagnosis: acute brain syndrome, associated with systemic infection. During the month prior to admission, he had been in The Queen's Hospital and Children's Hospital for acute encephalitis and postinfectious psychosis.

He was born out of wedlock to a Japanese mother by a Caucasian serviceman. At that time, she had previously been married twice and had three children, one placed in a foster home and two with her parents. For this son, she made a series of unsatisfactory private boarding arrangements, while she worked as a waitress to support him. When he was three years old, she married a Caucasian man. The couple has a daughter, and the patient has always been compared unfavorably with her. He had poor social adjustment from the time of entering school, showing aggressive, belligerent, stubborn, and negativistic behavior. He was twice studied at the Mental Health Clinic and found to have dull-normal intelligence.

At the State Hospital, family therapy was begun by a social worker and was continued after patient left the hospital. This was unsuccessful because of the father's need to dominate the situation. Because of the boy's continued bedwetting, minor delinquencies, and defiance of parental authority, his stepfather tried repeatedly to send him away from home, but no agency or institution would accept him under terms set by the father. He was known to the Juvenile Court for minor offenses, and recently had a brief stay in jail for car stealing. Condition: unimproved.

Patient No. 38 entered the State Hospital twice for brief stays at age 14. These admissions were stopgap measures while he awaited placement at Waimano Home. His father is an alcoholic who deserted the family when the patient was two years old. His mother had a "nervous breakdown" before his birth. The patient had surgery at age 2½ for a chronic subdural hematoma. He attended school through the third grade and was dropped out because of behavior problems and inability to learn. He had convulsions from age 12. In the State Hospital, he continued his Dilantin and phenobarbital medication, but had grand mal seizures anyway. His behavior was childish, negativistic and demanding. He has remained in Waimano Home since leaving the State Hospital. Diagnosis: chronic brain syndrome, with convulsive disorder, post-traumatic, and mild mental deficiency. Condition: unimproved.

Patient No. 39 had two short admissions to the State Hospital at age 16, while awaiting placement at Waimano Home. Diagnosis: chronic brain syndrome, associated with brain trauma with moderate mental deficiency. He was raised by his grandparents from age six months, because of his parents' divorce. At age six, he was in a car accident, was unconscious and remained in Children's Hospital for two months. He had paralysis of the third cranial nerve and encephalopathy with seizures as residuals of this injury. He had help from the Welfare Department and the Bureau of Crippled Children. Psychological testing at age ten showed moderate mental retardation. While awaiting Waimano admission, he became combative and could not be managed in a general hospital. At the State Hospital, he was incoherent, combative, and hallucinated. He had phenobarbital and phenothiazine. He remains now in Waimano Home. Condition: unimproved.

Few studies of long-range results of hospital treatment of psychotic adolescents have been reported in the psychiatric literature. Long-range studies of total mental hospital populations are more numerous. One of the best of these is a survey by Rennie[1] of 500 schizophrenic patients admitted to the Henry Phipps Psychiatric Clinic from 1913 to 1923. At the time of discharge from the hospital, 43 per cent were well or improved; 57 per cent left the hospital unimproved. At the end of 20 years the results were somewhat less favorable, with 27 per cent recovered, 13 per cent improved, and 60 per cent unimproved.

A detailed analysis[2] of 50 male and 50 female patients in the recovered group led to these conclusions, among others: "The most striking single factor for recovery seems to be a long-term contact with a physician or clinic. These patients are capable of accepting guidance and of resolving personal conflicts with the help of the psychiatrist. Important also are the presence of a favorable and understanding environment to which the patient can be returned and the help to be obtained from cooperative families in carrying out recommendations."

Annesley[3] reported experience with 362 patients admitted to the Adolescent Unit at St. Ebba's Hospital, Epsom, England, between 1949 and 1954 and followed for over two years. Half of the admissions were classified as behavior disorders; at follow-up 60 per cent were called recovered or improved. The number with affective (manic-depressive) disorders was small, but showed 93 per cent recovered or improved. Neuroses made up one-fourth of the sample, and at follow-up showed 83 per cent recovered or improved. The remaining one-fourth of the admissions suffered from schizophrenia. At follow-up, 19 per cent were considered recovered, 23 per cent improved, and 58 per cent no change or worse. The assessments of mental condition at follow-up were compared with that at the time the patients left the hospital; it was seen that the patients with behavior disorders, neuroses, and affective disorders continued to improve in the years following their hospitalizations, but the schizophrenics became worse. The prognosis in schizophrenia was considered to be poor, regardless of treatment given, whether it was phenothiazine medication, electroshock therapy, or psychotherapy alone.

Carter[4] reviewed 78 patients between 14 and 18 years of age, admitted to Shenley Hospital in England and placed on adult wards for custodial care. They received no somatic therapy or psychotherapy. Forty-seven of the sample were schizophrenics, and thirty per cent were found three

years later to be significantly improved. Seventeen were diagnosed as manic-depressive; of these 83 per cent were improved. Eight cases were called confusional, and all made a full recovery. Six were called chronic organic cases, and all six were considered unimproved.

Masterson[5] reported on 201 consecutive admissions to the Payne-Whitney Psychiatric Clinic of patients aged 12 to 18, during the period 1936 to 1950. This is a private psychiatric hospital in the New York Hospital-Cornell Medical Center; patients are voluntary and chosen for their amenability to psychotherapy. Follow-up from 5 to 19 years later was possible on 153 patients. Of the 83 diagnosed as schizophrenic, 33 per cent were found later to be significantly improved. Prognosis was much better in the neurotic group; out of 34 patients so diagnosed, all but two showed sustained improvement. Of the 20 psychopathic personalities, 55 per cent showed significant improvement. Most of the affective disorders were considered improved or recovered, and the organic reactions unimproved.

Lists of prognostic factors in adolescent schizophrenic disorders were devised by Carter[4] and Masterson[5] in these papers and showed some disagreement. They and Rennie[2] agree on the prognostic significance of the pre-illness social adjustment of the patient. Children considered emotionally healthy by their families and neighbors, and achieving well at school, will do better, if they become mentally ill in adolescence, than those who have always been considered peculiar and poorly related to others.

CONCLUSIONS

Improvement rates for adolescent patients treated at Hawaii State Hospital compare favorably with other reported series, especially in the schizophrenic and organic groups. This can be attributed to effective treatment at the hospital and to adequate outpatient treatment after hospitalization.

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Density and Social Problems

. . . Calhoun found that as the density of the population increased, the organization of culture gradually became unhinged and individuals began to display the most extraordinary types of pathologic behavior. There was an irrational tendency to crowd into a single, small area, which is referred to by Calhoun as a "behavioral sink." Some became timid, withdrawn, and then somnambulistic. Others began to fight incessantly in efforts to dominate the group. The females gave up the scrupulously tidy housekeeping which is the normal mark, and they made careless, inadequate nests or no nests at all, with the result that neonatal mortality became very high. Then, as the population density increased still further in this confined space, the "probers" appeared. These were small groups of three or four males which roamed the pen together and engaged in homosexual activities or in the mass rape of females, and in cannibalism. The most remarkable and disturbing characteristic of the probers was their hyperactivity. They kept in constant movement, hostile to all other rats in the colony and inexhaustible in their efforts to make trouble.

From *New York Medicine,* Vol. 17, No. 16, p. 563





The President's Page

Right now there is a major controversy brewing concerning the one-year residence requirement for medical licensure in the State of Hawaii. This controversy will be brought to a head when the Department of Health attempts to get emergency consideration of the Medical Practice Act at the Budget Session of the Legislature in February. With the recent interpretation from the Attorney General's office concerning nonlicensed physicians, the Department of Health feels it needs some change in the present law which will give it the power to provide temporary licensing of doctors for certain areas of the State which are chronically and recurringly without proper medical personnel.

This is only one of many changes that should be made in the Medical Practice Act—in fact, it needs a complete overhauling. The present Act with its one-year residence clause amounts to a tariff on brains and ability, and is not at all in the best interests of the public.

From the tone of the recent ruling of the Attorney General, one would gather that licensure confers a special mark of competence or ability on a doctor, and that no unlicensed physician must so much as intimate that he has a license, under pain of penalty, lest he mislead the public.

Nothing could be further from the truth. Actually, what does it mean when a physician becomes licensed? What can the public be assured of when they go to a licensed physician? Does his license mean that he has had a good medical education and was graduated from a Class A medical school? No. He may have graduated from a foreign diploma mill and practiced elsewhere for seven of the past 11 years.

Does it mean that he has recently passed an examination to test his general medical knowledge? No. He may have taken the National Board examinations 30 years ago and he may not have even treated a patient for 25 or even all of the past 30 years.

Does it mean that he has the skills necessary to perform the type of practice which he has entered into? No. It only means that he has some type of medical degree and that at one time or another he passed an examination.

Ah,—but there is one thing that the public can be certain of and take heart in, and that is, that this licensed doctor was either born in Hawaii (his mother may have just been passing through on the Mariposa) or has been a resident of Hawaii for one year!

Hawaii is certainly out of step with the rest of the nation, since only here are legal residence and physical presence made a requirement for medical licensure. It might not be so bad if the law required that certain training be taken, or that a prospective candidate work under another licensed physician during this year. This might possibly enhance his skills and ability so that he would be better able to practice his profession at the end of the year's required residence. A candidate who really wants to practice in Hawaii might spend a year "on the beach," during which time he would lose some of his skill and really be a less capable doctor when he takes his exams after this year of "rest" or minimal activity.

Why in the first place do we have such a law? As far as I can see, there is only one real reason: to keep down competition, to keep out new skills, and to confine, as much as possible, the practice of medicine to the "chosen few." As such, it is un-American and, I feel, just as unconstitutional as if we placed a tax on certain types of competitive products from the mainland U.S. Even today the doctors who advocate the continuance of the one-year residence law (in 1949 a vote was 5 to 1 for it, and in 1959 it had dropped to 2.7 to 1) look upon it as a necessary or desired bar to easy access to the medical brotherhood in Hawaii. They feel that because Hawaii is such a wonderful place to live there will be a flood of retiring M.D.'s who will come to Hawaii and take the "cream off the top."

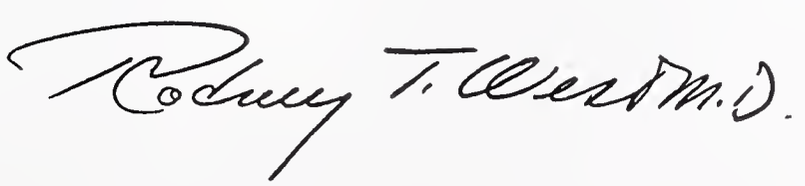
This is an unsound "bogey-man" philosophy, because at present there are already 380 doctors in the U.S.A. who have Hawaii licenses but who are not practicing in Hawaii, though they could come in tomorrow and go right to work. A great number of these have already practiced here at one time or another and have left to go to, from their point of view, a better place in which to practice. I think we are a little bit egocentric or provincial when we think that everyone, if given the chance, would practice in Hawaii or that many doctors are anxious to retire here. From my observation, a mainland Caucasian doctor (this would be the more likely type) would have an extremely difficult time in just trying to make ends meet if he wanted to retire here and do part-time practice. Most of this so-called "cream" would be "sour cream" as far as he was concerned.

This "cream skimmer" talk is really a red herring to cover up the main purpose of the law which, as I have said before, is to protect us local boys (I am one of them) from too much competition. At one time this law may have had a few good, if selfish, points in its favor, because 20 years ago a local doctor of Oriental or Hawaiian ancestry might have had a difficult time practicing on the mainland and Hawaii was really his only refuge. This is certainly not so today, for we all know of many well-trained and highly-respected local boys of all ethnic groups who are practicing, doing research, or teaching on the mainland and whose ability we could use to good advantage here in Hawaii, but who find that there are just as good places in which to pursue their medical careers as in Hawaii—or even better.

This protection, or as I choose to call it, this tariff, is therefore no longer necessary. Its continuance on our law books does nothing but discourage, and bar from our community, doctors with regular and specially needed skills, and thereby eliminate a certain amount of competition and is certainly not in the best interest of the public.

In closing, I would suggest that—since this issue is fraught with so much emotion—it might be wise for the Governor to appoint an impartial citizens' committee empowered to investigate this state's medical needs and come up with recommendations for changes in the Medical Practice Act which might:

1. Give the Board of Medical Examiners the power to grant a two-year provisional or probationary license to all new physicians so that we would have a chance to find out more about them before granting a permanent license;
2. Eliminate the blanket acceptance of all diplomates of the National Board—no matter how many years ago the examination was taken;
3. Eliminate that absurd part of the law (also probably unconstitutional) in which the State practically assumes the power of granting the title of Doctor to its citizens;
4. Remove the one-year residence clause, which is nothing but a tariff on brains and ability;
5. Eliminate the so-called loophole clause that permits the unlicensed physician to practice under a licensed physician; and
6. Redefine the practice of medicine to include the treatment of diagnosis of emotional disorders.



HAWAII MEDICAL JOURNAL

Editorials

The Other Side of the Coin

Our initial view of the proposal for a two-year medical school at the University of Hawaii was that the cost would be excessive, since such a small number of students is to be expected. We still do not believe the enterprise can be justified on the basis of the need to educate medical students.

As a byproduct of an integrated curriculum in biomedical sciences, however, such an educational program would do more than just turn out a dozen or so third-year medical students, and it deserves to be reappraised on the basis of these secondary considerations.

A major gain would be the strong support it would provide—of necessity—for the intern and resident training programs in our hospitals. The plan envisages a University faculty member, a well-qualified physician, in each of the principal hospitals, to oversee and coordinate the clinical teaching program for the medical students. With this arrangement the full implementation of the Michael-Uhl Report is virtually assured. Without it, its chances seem at best a little remote.

Another important gain would be the stimulating, elevating effect on the University and indeed the entire community, of the importation of professional talent for such a teaching program. The stimulating effect on other departments of the University would be felt beyond the confines of the campus, and in areas outside the hospitals.

The imaginative plan being developed by Dr. Robert Tschirgi for the new venture seems certain to attract national attention; admiring attention, probably. Some features of it will seem pretty far out to the conservative mind, but many will attract favorable comment from the start, and all will be watched, when they go into action, with great interest. Nothing about it looks dull!

So despite our initial misgivings, which persist, we acknowledge that there are the usual two sides to the question. And we have no doubt that the plan, if (as seems likely) it is to be pursued anyway, should and will receive vigorous support from the medical profession.

Crazy Man

How scientific is psychiatry today? Perhaps we shall only be able to tell in retrospect. Two generations ago we could have told the stature of pathology, or a generation ago that of surgery. Today we might declare that endocrinology is acquiring a solid basis in biochemistry, as is genetics. Where does psychiatry stand on this time-scale?

We can claim a major contribution to medicine in the tranquilizers, with the energizers helping to round out the picture. We can hold forth the general reliability of convulsive therapy. We can promise a new dimension in social modalities, such as psychodrama or community planning. Yet we should have to admit that these developments of the past quarter century, together with psychodynamics in the first quarter, constitute empirical advances, however valuable. Psychiatry is still a far cry from being an exact science.

Will it ever become so? Prophecy can be a risky business, as witness Benjamin Rush's prediction in 1812 that hydrophobia would be the last to be cured and arteriosclerosis the first! Are we in a better position today to foretell the future of psychiatry, if we are not sure what viewpoint to take? Let alone what ignorance to confess! We do have the humility to acknowledge the multiple etiology of mental disease, which puts us on a par with cancer research. We have the modesty to recognize the need for a broad approach to mental health, which recalls the dawn of hygiene in the last century.

What new vistas do we have? Neurophysiology offers chemical explanations for action potentials, with recordings that would fit a giant computer and invite a cybernetic interpretation. The behavioral sciences from the other end of the spectrum look toward an evolutionary theory of human psychology. Perhaps the answer is not too difficult for us to see, but is just being blocked from view by some prejudice of our own making.

Let us again take the analogy of cancer research. We have looked on neoplasia as a disease, assuming an external causation. Suppose we were to learn that free growth is native to the single primordial cell and that intracellular controls such as the interferons keep it within bounds in the interests of the larger organism. Then if some factor were to interfere with the interferons, unrestricted growth would subsequently prevail.

We may have a similar clue about the origin of psychosis from the recent advances in therapy already mentioned. Electroshock and tranquilization have to do with the control of psychic tension in terms of restoring a balance between excitation and inhibition. Another example is provided by electroencephalography, which reveals a smooth alpha wave pattern in the anthropoid—like fine ripples on a pond, as in the human brain—but a turbulent wave action in the simian and the human alike during sleep.

Now let us suppose that the organization of our psyche is conditioned upon controls, built up by human culture, which have established a norm of neurosis. Then when some factor or factors interfere with this precarious balance of exciters and inhibitors, an underlying primitive pattern takes over. We are familiar with it in dreams and might call it the australopithecine norm. Somehow it has become misnamed psychosis. So everybody is . . .

crazy man!

J. Kendall Wallis, M.D.

"Intent to Imply . . ."

May an unlicensed physician refer to himself orally, or designate himself in writing, as "Dr." or "M.D."? A recent opinion by Deputy Attorney General Peter C. Lewis said that he could not, on the ground that the use of these expressions was a tacit claim to be a duly licensed physician.

Since a series of Attorneys General have agreed that Hawaii law permits unlicensed physicians to practice medicine "under the direction and with the approval" of a licensed physician, during the time they are accumulating their required year of legal residence here, this question and this decision affect a substantial number of physicians.

Now a clarifying statement has been issued by Mr. Lewis, to the effect that the use of the expressions "M.D." or "Dr." is improper and illegal only if they are used with the *intent* to imply that the physician using them is licensed.

It seems clear that the display of a doctor's name to the public, with "Dr." or "M.D." appended, is an invitation to the public to consult him professionally, and implies that he is licensed to render the proffered services.

It seems no less clear, on the other hand, that a physician's use of "Dr." either orally or in writing, or of "M.D." in writing, is intended in all other situations solely to indicate that he is a duly qualified graduate of a medical school, a Doctor of Medicine. If he wishes further to indicate that he is a *licensed* physician, he does so by displaying his license on his office wall.

We applaud the reasonableness of Mr. Lewis's clarifying opinion. It appears to us to effectively eliminate the unreasonable view that an unlicensed physician could not so much as pick up the telephone and say "This is Dr. ..... speaking." Those Doctors of Philosophy or Divinity who like, as many quite properly do, to be addressed as "Dr.," may also take heart!

Medical Careers

As part of its contribution to the people of Hawaii generally and to the youth of Hawaii in particular, the Hawaii Medical Association is sponsoring the second annual Medical Careers Day February 21. Selected high school students from all counties will have an opportunity to visit Honolulu hospitals and to talk with physicians, as part of a program to interest them in entering medicine as a profession.

On February 26, the Hawaii Medical Association's Careers Committee will cooperate with other groups of medical professionals, including medical technologists, nurses, and radiation technicians, in displays on medical and paramedical careers at the second University of Hawaii Careers Day, to be held at Hemenway Hall.

In the center fold of this issue of the Journal, you will find your copy of a chart, entitled "Health Careers for Hawaii's Youth in the Sixties," prepared under the direction of the HMA Careers Committee. This chart could be posted in your office, or given to your community Boy Scout Headquarters or to your children's school for posting. Additional copies will be available from the HMA Executive Offices.

There is a need in the community for information on health careers. Can we do other than answer it?

HAWAII MEDICAL JOURNAL

Bureau of Medical Economics*

• *To many professional men, the word "collector" is one of the most distasteful in the English language. Afraid of repercussions, many medical men write off delinquent accounts which are, in effect, good collectable money, rather than turning them over to a reputable agency.*

Let us examine your position: You have fulfilled your duties and obligations to your patient. You have given the benefit of your years of medical knowledge and experience, and in many cases you have supplied drugs, for which you have paid. Your assistant sends out the usual monthly statement, and nothing happens. In the ensuing months more statements go out, but still no payment. Your aide phones the debtor, and as diplomatically as possible requests payment. It doesn't arrive, and after a few more half-hearted attempts, the account is allowed to languish and is finally written off.

Many doctors do not use collection agencies because they feel to do so would mar the doctor-patient relationship. Far from that being the case, if accounts are handled properly (and most good agencies know how), an agency can, and in many cases does, bring the patient back to the doctor. When an account is given to a reputable agency, the collector knows that one of his prime duties is to protect, or to rebuild, the good will that had previously existed.

In a case of genuine financial hardship, the interviewing collector will show sympathy toward the debtor, and will convey the fact that the doctor to whom the debt is owed is concerned about the well-being of the patient. A good collector, in most cases, can make an arrangement agreeable to both doctor and debtor. The good collector is always a sympathetic listener, and the writer can affirm that any person who has been sick and owes money needs a sympathetic listener.

All this has the effect of building good will between doctor and patient, proving to the debtor that the doctor is interested in the patient's welfare, even though through a third party.

True, there are other types of debtors—the ones who have no intention of fulfilling their obligations, or who put off paying until they are forced by threat of litigation. Such types are well known to the agencies, and are handled in a fitting manner.

Most debtors, however, are honest people who have fallen into financial difficulties through no fault of their own. High medical bills, for which they are unprepared, usually are the cause. The agency will probably know more about your patient than you do, because if he is a habitual delinquent, there is sure to be information about him on file. In the Hawaii Bureau of Medical Economics, delinquent histories on approximately 100,000 people have been compiled over the years.

At this point it might be worthwhile to add a word about another type of collection agency—that of the shabby one-room office, employing flashy salesmen with a machine-gun pitch. There are a few of these around. They make all sorts of rash promises of high returns, with a low percentage share for themselves.

In picking your agency, avoid anything with the words "world-wide" or "national." Dependable agencies are, for most part, local. Second, watch out for agencies who offer you unusually low rates. Anything from 33⅓% to 50% is the usual fee. Another point to keep in mind is that a reputable agency never asks a client to sign a contract. Good agencies are always affiliated with one, sometimes two, national associations, and in most cases have been established in your area for a number of years.

A close liaison between your secretary and a good collection agency can help your practice financially. Let her make a habit of checking with the agency on any doubtful clients. In this way, she will forestall many bad accounts. Use a good agency, and use it wisely. There are many things a service representative can teach your office personnel. After all, they've been handling delinquent accounts for many years, and so should be expert—far more expert than you, who haven't the time to make a close study.

There will always be bad accounts. There will also be accounts that are uncollectable. These are inevitable, and will always be with us. But, remember, many of those accounts that you write off can and will be collected if you pass them over to a good agency. After all, it is your money. So why not get it?

GABRIEL ROGERS
Manager

* Owned and operated by Honolulu County Medical Society.

HAWAII MEDICAL JOURNAL

This Is What's New!

• **Kerosene** absorbed through the skin or gastrointestinal tract and presumably respiratory tract can cause **bone marrow depression** with pancytopenia or selective depression of granulocytes, erythrocytes, and so forth. Three cases are reported from Chicago. The authors suggest that kerosene as an excellent fat solvent readily penetrates the marrow fat and exerts its toxicity at least partially through this mechanism. Note: Kerosene may be the responsible agent in cytopenic states resulting from the use of various **insecticides.** (*Am. J. Med. Sci.* [Aug.] 1963.)

• The **mortality** risk for the patient with **coronary disease** undergoing surgery is **two to three times** that of the total population having operations. The risk for a given patient with coronary disease depends upon a number of variables, the most important of which are the clinical manifestations of the coronary disease with the presence or absence of various complications. Age, type and duration of surgery, anesthesia, and so forth, are less important factors in considering risk. (*Am. J. Cardiol.* [Sept.] 1963.)

• Various **isotopes** are now being used in the diagnosis of **brain tumors.** With techniques that are still relatively crude, the diagnostic accuracy and precision of localization by isotope brain scan are almost unbelievable. A London hospital using radioarsenic reports correct localization in 90 per cent of patients scanned. This high percentage is approximately the same as reported by other physicians using the same or different isotopes. (*Proc. Royal Soc. Med.* [Aug.] 1963.)

• Fusidic acid (Fucidin) combined with phenoxymethyl penicillin has proved extremely effective in clearing patients of resistant staphylococcal infections. Fucidin, 500 mg t.i.d., and phenoxymethyl penicillin, 300 mg, cured staphylococcal infections in 21 patients some of whom had failed to respond to chloramphenicol, erythromycin, and methicillin. (*Lancet* [Sept.] 1963.)

• There is a suggestion of a metabolic relationship between cholesterol and uric acid. Recent work in New York reveals that spontaneous changes in **serum cholesterol** and **serum uric acid** tend to **parallel** one another, with the increase in cholesterol usually associated with a similar increase in serum uric acid and vice versa. The precise nature of this metabolic link has yet to be defined. (*Metabolism Clin. Exper.* [Aug.] 1963.)

• The release of renin from the kidneys has long been regarded as being secondary to renal ischemia. Several workers in Cleveland who have been extremely close to this problem concluded after perfusion experiments, that **release of renin** "appeared to be **mediated by a renal baroceptor** rather than by **ischemia.**" Their studies indicated that a small reduction in renal perfusion pressure resulted in release of renin even when there was no reduction in renal blood flow. (*Science* [Aug. 30] 1963.)

• The third report of **systemic lupus erythematosus** in identical **twins** further strengthens the case of the **strong genetic factor** in this disease. In addition to both teenage girls developing systemic LE, various members of the involved family without signs or symptoms of LE had positive cephalin flocculation tests, as well as hypergammaglobulinemia. (*JAMA* [Aug. 24] 1963.)

• Since the time of Sydenham, **gout** has been regarded as a disease of the upper social crust. A team of investigators at the University of Michigan finds higher uric acids in upper levels of society. The **high uric acid** group tended to be **more intelligent** and better all-round performers than the low uric acid group. The serum uric acid did not correlate with social class of family of origin. (*JAMA* [Aug. 10] 1963.)

• The computers, already reading electrocardiographs with higher degrees of accuracy than electrocardiographers, now are invading the field of radiology. A **digital computer** can "read" a **chest film** and retrieve the image with extreme precision even with low resolution scanning. (*Radiol.* [Aug.] 1963.)

• Patients with **metastatic carcinoma** of the breast may **die from correctable hypercalcemia** rather than from the metastases themselves. Hypercalcemia should be suspected in the patient with metastatic disease who is doing relatively well and then develops nausea, vomiting, anorexia, or other signs of increased intracranial pressure. Extreme lethargy or semicoma may be due to hypercalcemia rather than to cerebral metastases. Estrogenic hormones, which may inhibit the metastases, also cause an increase in serum calcium. Recommended treatment: (1) Increase fluid intake either orally or IV; (2) discontinue calcium-mobilizing drugs, especially hormones; and (3) start corticosteroids. (*Ann. Surg.* [Mar.] 1963.)

F. I. Gilbert, Jr., M.D.

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii.....

This is the forty-seventh installment of In Memoriam—Doctors of Hawaii.

Gurdon Potter

Gurdon Potter was born in Buffalo, New York, on February 19, 1876, and was the son of Edward Ells and Harriet L. (Grant) Potter. His father was a Commodore in the U.S. Navy.

Dr. Potter was educated at the Episcopal Academy and the Forsyth School of Philadelphia. His medical degree was received from the University of Pennsylvania in 1899.

The doctor began his practice at Belvidere, Illinois. Coming to Hawaii in 1913, he established a medical practice at Pepeekeo, Hawaii. He also served as government physician for the East and West Kau districts and had an office in Hilo.

On March 31, 1917, Dr. Potter married Frances L. Moir at Hilo.

In 1920 he moved to California locating in Oakland where in later years he limited his practice to surgery.

Dr. Potter died December 2, 1943, at Oakland at the age of 67.

At the time of his death, he was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association. During his years on Hawaii, he was a member of the Hawaii Medical Society.

John Edwin McKillop

John Edwin McKillop, born in 1884, received his medical degree in 1911 from the University of California Medical School.

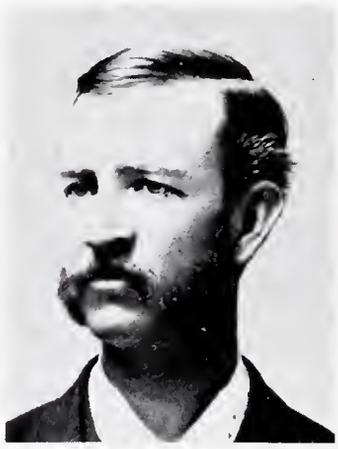
In October, 1913, Dr. McKillop was appointed government physician and registrar for the district of South Kohala, Hawaii, and was also in charge of the Kona Hospital. By 1923 he was located in Los Angeles, and in 1931 he was professor of Medicine (communicable diseases) at the College of Medical Evangelists and on the staff of the Los Angeles General Hospital.

Dr. McKillop was accidentally drowned on July 25, 1932, at Santa Monica. At the time of his death, he was 48 years old.

He was a member of the Los Angeles County Medical Association, the California Medical Association, the American Medical Association, and a former member of the Hawaii Medical Society.

Tandy Allen

On September 20, 1889, Dr. Tandy Allen arrived in Honolulu aboard the "Australia" from San Francisco. The doctor left almost immediately for Hana, Maui, where he had been appointed government physician to replace Dr. Robert Williams, who had resigned. News from Hana in October, 1892, tells of a surprise party given in his honor and adds, "Dr. Allen must have felt proud of the reception given in his honor, judging by his glowing and happy countenance, and he is in every way worthy of it, as his uniform kindness, hospitality and skill have endeared him to all who have the pleasure of his friendship."



TANDY ALLEN

The doctor remained at Hana for almost six years, weathering an epidemic of "la grippe" in 1893 when he treated 200 cases within two weeks and his own serious illness the following year. In 1895, due to ill health, he resigned and left the Islands.

Returning in December, 1897, Dr. Allen applied for Dr. H. A. Lindley's position in South Kona, Hawaii, during the latter's absence, and in March, 1898, received a temporary appointment as government physician for that district. In September, 1899, Dr. Lindley still having not returned, Dr. Allen was given permanent status. The doctor practiced there until his death, which occurred suddenly at his home in Kona on April 11, 1901. At the time of his death, he was 44 years of age.

The Evening Bulletin in reporting his death commented, "Dr. Allen was a great friend of the Hawaiian and had never refused the call of suffering or sickness, from rich or poor." His funeral was held at the Kona Episcopal Church.

Hawaii Academy of General Practice

The American Academy of General Practice has a membership of 28,000, the largest next to that of the AMA. General practitioners number some 59,000 in the USA, but the figure is a very round one, probably including a great many MD's who are not eligible to become members of AAGP. There are barriers to membership in the way of schooling, nature and years of practice, etc.

BOARD OF GENERAL PRACTICE?

The AAGP has, for the past several years, considered the matter of a certificated Board of General Practice. I have always regarded the promotion of this (by a small, militant minority of our membership) as simply a scheme to establish prestige by edict. In fact, it has arisen in response to the seeming need of keeping the GP up with the specialist, especially on the medical staffs of hospitals. So far, the House of Delegates has not developed a majority in favor of such a thing—probably because of a feeling that no advantage would accrue therefrom.

By and large, the general practitioner builds his prestige on the blocks of his medical knowledge, his relationship as a physician to the entire family, and his professional reputation for honesty in the hospitals. With respect to the latter, he is judged, perhaps over-critically, by his specialist colleagues, who, understandably jealous of their own prerogatives, are also suspicious of the general practitioner's capabilities just because his activities are so "general." How can a man know very much about anything when he has to know a little about everything?

It is in his own office that the general practitioner holds full sway. The quality of his efforts in this, his own castle, is not well known to his colleagues. The specialists of his choosing for referrals may appreciate the business he gives them somewhat more than is conducive to a proper ethical relationship, for example, in the matter of deciding on hospital privileges for the general practitioner in question. In his own office, the generalist is responsible only to his patients, within the law, that is. He may be rated by them just as highly for his art, despite his lack of the knowledge of the science, of medicine. The lay public is not in a position to evaluate the methods used, although it is becoming increasingly more educated to such judgment. Therefore, Board certification, much less the plaque signifying membership in the AAGP, will not mean anything to his patients for many years yet to come.

If certification—"prestige by edict"—in the eyes of his hospital colleagues, will mean no more than that for the generalist, and will probably *not* increase his chances of obtaining hospital privileges; if he does not need such a piece of paper on his office wall, then why all the fuss about another Board? The answer lies in a change in the model itself: the "new" GP will have a different image.

The Commission on Education of the AAGP is considering the future of postgraduate hospital training for generalists. It is well aware of the fact that the days of a newly graduated MD who hangs up his shingle after one year of a rotating internship, are passing. If specialism requires another three or more years of hospital in-residence training, then surely the man who really wants to go into the field of family practice should be trained for as many, if not more, years in hospital centers.

THE "NEW" GP

The generalist of the future, then, will be an MD who will be well grounded in internal medicine, minor and intermediate surgery, normal and complicated obstetrics, minor and intermediate gynecology, pediatrics, and psychiatry. He will be a family doctor who not only will be better qualified to recognize serious illness, complications, and adverse reactions to treatment, but will be better trained in managing appropriate therapy. Well aware of his own limitations, he will not abuse his new and greater knowledge and capabilities, but will call on his specialist colleagues to help or take over as indicated. They should treat him with a greater respect, and allow him to participate more actively in the team medical effort that has become so all-important in modern medical practice, particularly in hospitals.

When the "new" GP becomes an established and recognized entity, a four-to-five-year hospital-trained graduate, then and only then will it become important to have a Board of General Practice certification. Its emblem might well bear the likeness of Leonardo da Vinci, who excelled in many fields. The MD so certified would be in a very different class from the one-year-rotating man, and should be so recognized. The prestige of becoming a "super-specialist" might attract the medical neophyte away from the simple specialism that, in modern times, makes for gun-barrel vision.

J. I. FREDERICK REPPUN, M.D.
Secretary-Treasurer

HAWAII MEDICAL JOURNAL

Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

November 20, 1963—6:00 P.M.
Oahu Country Club

PRESENT:

Dr. Rodney West, presiding; Drs. Allison, Chinn, Fong, Giles, Miyamoto, Nishijima, and Wade, plus Mr. T. Thorson. Drs. Andrews and Lum were absent.

MINUTES:

The minutes of the July 24, 1963, meeting were approved as published.

SECRETARY'S REPORT:

The circulated report was reviewed.

ACTION:

It was voted to drop the following members for nonpayment of dues: Drs. Angie Connor (Honolulu) and Lawrence Van Loon (Maui).

It was voted not to approve request for waiver of legislative assessment due to financial hardship the following doctors: Drs. Faus, Marks, You. Action on Dr. Jenkin's delinquency was deferred. Dr. Bockrath's request was approved. Dr. Saunders' request will not be approved unless it can be substantiated.

It was voted to waive the following members' dues because of illness: Drs. Narita and Kemp.

It was voted to drop the following members from the Hawaii Medical Association roster for nonpayment of assessment and advise their county societies: HAWAII—M. H. Chang.* HONOLULU—Samuel Buist,* Charles T. A. Ching,* Walter Chung,* Royal Delaney,* J. P. Frazer, Paul Gebauer,* C. C. Kimura,* M. Nishihara, Albert M. Okamura,* Coolidge S. Wakai,* Elizabeth Wang,* Y. T. Wong.* MAUI—Wolfgang Pfaeltzer.*

It was voted to accept the Secretary's report as amended.

TREASURER'S REPORT:

The report was reviewed as circulated.

Dr. Chinn stated data is still being gathered on retirement plans for employees.

There was a lengthy discussion about the Hawaii Medical Association's moving into new offices across the hall from the present offices. Action was deferred pending Mabel Smyth Board meeting.

The Treasurer's report was approved as circulated.

REPORTS OF STANDING AND SPECIAL COMMITTEES:

Letters were sent to all committee chairmen to ask what they are doing and what they plan to do.

Arrangements: The annual meeting will be held from April 29 to May 3, 1964, at the Princess Kaiulani Hotel.

It was suggested that the 1965 annual meeting be held on one of the neighbor islands, preferably Kauai. Dr. Wade advised the Council that Kauai physicians feel that the annual meeting should stay in Honolulu. It was recommended that plans for the annual meetings should start two to three years in advance, and that a program committee be appointed soon to make plans for the next annual meeting.

Awards: Dr. Giles stated that a plaque will again be given as an award.

Cancer: No meetings.

Careers: Dr. Allison suggested that Careers Day projects should be a county rather than a state function. Mr. Thorson stated that the Honolulu County Medical Society had cancelled their project because of the conflicting date. It was suggested to have the committees be coordinated.

ACTION:

Careers Day will be held on February 21, 1964.

Communicable Diseases: The Committee reviewed influenza immunization and made recommendations. This, as well as smallpox and oral polio immunization, will be discussed at the November 21 meeting with Dr. Bernstein. The Committee feels there should be better coordination between state and county committees. Often we overlap in our activities and either waste time researching a subject that has been worked out or develop different policies. The Committee will coordinate with Disaster Committee before tetanus immunization policy is drawn up.

Conventions and Seminar Committee: The report was reviewed.

ACTION:

It was voted to authorize this committee to make arrangements for a chartered flight to the Orient for Hawaii Medical Association members.

Crippled Children: No meeting yet.

Disaster: It was decided to have the matter of who should be in control if there was an alert taken up with Dr. Boone, Chairman of the Disaster Committee.

Federal Medical Services Committee: The report was reviewed.

ACTION:

It was voted to authorize the President to sign an extension of the contract if this is recommended by the committee.

Diabetes: No report.

Chronic Illness and Aging:

ACTION:

It was voted to request the Chronic Illness and Aging Committee to form a subcommittee to investigate indigent medical care and the government physician set-up.

Heart: The Committee reviewed a movie "Heart Attack" and recommended that the Health Department not buy it since it was felt "Pulse of Life" was adequate.

Hawaiian Academy of Science: No report.

Hospital Liaison: The chairman, Dr. Mills, has resigned and recommends that the Committee should be continued and should increase its activities and study in the following areas: (1) Clarification of the hospital and doctor relationship regarding hospital staff privilege, (2) Interpret for the Association and support the county societies in active study program of hospital utilization, (3) Involve itself in the area-wide hospital and health facility planning.

Maternal & Perinatal Mortality Study: The Committee proposes to develop the following activities: Visit Hawaii, Maui, and Kauai at least once during the year. Encourage each major hospital to conduct its own perinatal mortality study. Work closely with Legislative Committee to have enacted a statewide medical examiner act system. The bill was drafted and introduced during the last session. (Letters have been sent to each county on this.) The Committee would like to have more anesthesiologists and internists in its make-up.

Legislative: No report.

Medical Care Plans & Fees: Dr. West said the Committee will come up with a report soon.

Medical Education: No report. The Committee plans a dinner meeting for Dr. Tschirgi on November 26. After

continued page 238

* Subsequently cleared.

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Book Reviews

★Cecil-Loeb Textbook of Medicine, 11th Ed.

By Paul B. Beeson, M.D., and Walsh McDermott, M.D., 1,835 + lx pp., $19.50, W. B. Saunders Co., 1963.

THIS 1963 QUADRENNIAL edition of Cecil and Loeb, a standard reference book in medicine, is the product of a new editorial staff. Paul Beeson and Walsh McDermott, who succeeded Cecil and Loeb as the editors, have expanded the associate editorial staff from three to five, the late Harold G. Wolff being the only editor from the 1959 staff. There are, in addition, 66 new contributors and over 80 new subjects. The volume is predictably larger; this time by 170 pages. The twin-volume set is optional at $23.50.

The infectious diseases have been more conveniently grouped with respect to their major effect on the body: i.e., Respiratory Tract Viral Diseases, Central Nervous System Viral Diseases, etc. The section on gastrointestinal diseases have been usefully expanded, and those on cardiovascular and pulmonary diseases changed but little. The section on kidney diseases has been extensively reworked with benefit. The inborn errors of metabolism have been rightfully relegated broader treatment, and the section on metabolic disease more logically limited to fluid and electrolyte, protein, fat, and carbohydrate abnormalities. The fairly extensive section on central nervous system diseases remains largely unchanged from previous editions.

As new topics appear, many of the staple subjects of lessening importance remain *in toto*, such as the 14-page section devoted to syphilis, the seven pages each discussing malaria and leprosy, and the eight pages concerning kala-azar. In contrast, the entire group of collagen diseases retains only the 20-page treatment accorded them in 1959. One new section is that on diseases of the skin. This topic is a difficult one to treat fairly in a reference work in medicine, particularly in just 24 pages. There are, accordingly, many areas uncovered, and yet such entities as Lethal Cutaneous and Gastrointestinal Arteriolar Thrombosis, Angiokeratoma Corporis Diffusum Universale, and Incontinentia Pigmenti are included rather than being relegated to a reference dermatologic text.

This textbook of medicine, as in the past, fills the basic need for an all-around compendium of medical diseases. The major faults are related to failing to undertake a comprehensive streamlining of the subject matter rather than making the characteristic multiple but minor modifications from edition to edition. It remains, however, an excellent general medical reference text for use by any medical doctor in any field.

JAMES J. BALL, M.D.

The Care of Minor Hand Injuries, 2d Ed.

By Adrian E. Flatt, M.A., M.D., F.R.C.A., F.A.C.S., 274 pp., $10.50, The C. V. Mosby Company, 1963.

THIS IS AN EXCELLENT little book on the care of the injured hand, though some of the injuries described, such as tendon repair, are not minor. The book is separated in two parts. The first deals with general principles. The illustrations of the action of the muscles are very well done. The second cares for specific injuries. One can readily refer to the particular chapter where detailed instructions will be found to treat an injury. Here, also, one will find pictorial illustrations showing, step by step, the surgical repair of the injured part.

This book should be available to all those who care for the injured. It should be found among the books in a hospital emergency room.

WAYNE WONG, M.D.

Management of Anxiety for the General Practitioner

Edited by Nathan K. Rickles, M.D., F.A.P.A., 108 pp., $5.00, Charles C. Thomas, 1963.

THIS BOOK IS difficult to evaluate. At times it merely states the obvious. At times it does so in esoteric terms that make it difficult to digest.

There are items of interest and value like the chart of all the drugs available for varying forms of anxiety. This is so important a problem that any attempt to digest the meaning of anxiety is valuable.

It is rather sad that so much of it contributes little in the practical handling of the problem.

J. ROBERT JACOBSON, M.D.

★Aids to Bacteriology for Nurses, 2d Ed.

By E. Joan Bocock, S.R.N., S.C.M., D.N. (London) and Katharine F. Armstrong, S.R.N., S.C.M., D.N. (London), 188 pp., $3.00, Williams & Wilkins Company, 1962.

THIS SMALL PAPERBACK is, like many of the compact volumes produced in Britain, a concise, well-written, and eminently practical textbook. It is useful to a nurse as a quick review of basic principles, or as a handy reference book. With commendable economy in the use of words this book supplies the information needed by the professional nurse on the characteristics of bacteria and viruses, the identification of causative organisms in infections, immunity, and the control and containment of pathogens in clinical situations.

This book points out a principle in nursing care that is too often overlooked—that infections are not always transmitted, but are the result of breakdown of the patient's resistance to his normal flora during his confinement.

In the chapter on nursing procedures, several proprietary disinfectants are mentioned. These may be unfamiliar to American nurses, but in most instances they are adequately identified by generic names.

In summary, this is a useful, well-illustrated, and easily read text that is recommended for the busy nurse or nursing student.

SHIRLEY M. TREFZ, Ph.D.

★Handbook of Pediatrics, 5th Ed.

By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D., 602 pp., $4.00, Lange Medical Publications, 1963.

THE FIFTH edition of this excellent and well-known handbook has been again revised to keep it as up to date as possible. Some new material has been added, and some of the charts revised to what seems to me a less convenient paragraph form. Not intended as a textbook, this handbook is an excellent reference manual for anyone caring for children.

JOHN R. STEPHENSON, M.D.

★A Manual of Diabetes for the House Officer

By William T. Nunes, Major, MC., 108 pp., $5.00, Charles C. Thomas, 1963.

THIS LITTLE 88-page outline is a gem. Its purpose is to provide a concise, understandable guide for the therapy of the diabetic patient by the busy house physician. It succeeds quite well and will also help the man in general practice who needs to make a decision in a few minutes.

continued page 218

★ means highly recommended.

HAWAII MEDICAL JOURNAL

New Members



Truett V. Bennett, M.D.

Otolaryngology
888 South King Street
Honolulu, Hawaii 96813

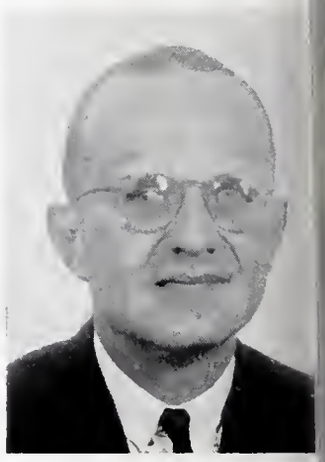
Otolaryngology
Washington University, 1945
Internship—Missouri Baptist Hospital, St. Louis, Mo.
Residency—University of Virginia Hospital, Charlottesville, Va.



Max Gerald Botticelli, M.D.

Internal Medicine
1133 Punchowl Street
Honolulu, Hawaii 96813

Internal Medicine
Wayne State University, 1956
Internship—The Queen's Hospital
Residency—Monterey County Hospital, Salinas, Calif.
Mayo Clinic, Rochester, Minn.



Edward L. Chesne, M.

Internal Medicine
888 South King Street
Honolulu, Hawaii 96813

Internal Medicine
Northwestern University, 19
Internship—Cook County Hos
Chicago, Ill.
Residency—U. S. Research Ho
Chicago, Ill.
Los Angeles County General H



Thomas C. Brown, Jr., M.D.

Radiology
1697 Ala Moana Boulevard
Honolulu, Hawaii 96815

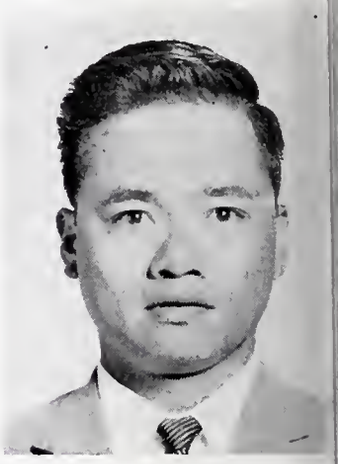
Indiana University, 1945
Internship—Indianapolis City Hospital
Residency—Hermann Hospital
Mid. Anderson Hospital, Houston



Donald F. B. Char, M.D.

Pediatrics
326 North Kuakini Street
Kauikeolani Children's Hospital
Honolulu, Hawaii 96817

Temple Medical School, 1950
Internship—Atlantic City Hospital
Residency—St. Christopher's Hospital for Children



Reginald C. S. Ho, M.D

Internal Medicine
888 South King Street
Honolulu, Hawaii 96813

Internal Medicine
St. Louis University School o
Medicine, 1959
Internship—Cincinnati Gener
Hospital
Residency—Cincinnati Gener
Hospital, Cincinnati, Ohio
Fellowship in Hematology—
Barnes Hospital, St. Louis



inie Grant Howard, M.D.

Orthopedics

1697 Ala Moana Boulevard
Honolulu, Hawaii 96815

Orthopedic Surgery
Northwestern University, 1939
nternship—Rochester General Hospital
esidency—Assistant, Rochester General Hospital



Arthur Wright Neilson, Jr., M.D.

Internal Medicine

888 South King Street
Honolulu, Hawaii 96813

Internal Medicine
St. Louis University School of Medicine, 1956
Internship—St. Luke's Hospital, St. Louis, Mo.
Residency—St. Luke's Hospital, St. Louis, Mo.
Scripps Clinic
La Jolla, Calif.



Alexander Roth, M.D.

Allergy

1697 Ala Moana Boulevard
Honolulu, Hawaii 96815

University of Kansas Medical Center, 1950
Internship—University of Michigan Hospital
Residency—University of Kansas Medical Center



Earl Dean Lovett, M.D.

Administration

udent Health Service, U. of H.
Honolulu, Hawaii 96822

University of Iowa, 1934
ternship—Mary's Help Hospital
Residency—Yocom Hospital



Francis T. Oda, M.D.

General Surgery

1409 Kalakaua Avenue
Honolulu, Hawaii 96814

University of Michigan Medical School, 1956
Internship—University Hospital
Residency—University Hospital



Dudley S. J. Seto, M.D.

Internal Medicine

Room 203, 205 S. Vineyard Street
Honolulu, Hawaii 96813

University of Michigan, 1958
Internship—Indianapolis General Hospital
Residency—Cleveland Clinic
Clinical Associate—Dept. of Artificial Kidneys and Renal Disease

County Society News



Bernice R. Walters, M.D.
Anesthesiology
888 South King Street
Honolulu, Hawaii 96813
Woman's Medical College of Pennsylvania
Internship—St. Francis Hospital
Residency—Stanford Hospital, San Francisco
Research & Education, Chicago V.A. Hospital, McKinley, Texas



James B. H. Young, M.D.
Urology
252-A Alexander Young Building
Honolulu, Hawaii 96813
St. Louis University, 1958
Internship—St. Louis City Hospital
Residency—St. Louis City Hospital

Hawaii

The August 22 meeting was opened with a movie entitled "Management of Hepatitis and Portal Hypertension." It was voted to approve an amendment to the HMSA participating physicians' contract which relates to the examination of records. Approval of Dr. Tabrah as a pediatric consultant to the Department of Social Services was given. Acknowledgment was made of the donation of 10 shares of Realty Investment Company stock to the Society's scholarship fund by Mr. Pete Beamer. It was voted to purchase a round trip ticket for Dr. George Bracher to attend a course on renograms at Ann Arbor.

There was considerable discussion on the problems of County Physicians, especially in relation to unattended deaths. Dr. Wipperman stated that these should be handled by the government physician assigned to the area. Dr. Steuermann recommended abolishing the government physicians in favor of a fee-for-service system. It was voted to write the Department of Social Services and offer the Society's services and advice concerning the medical care of the indigent.

The HMA president, Dr. West, spoke on renograms and their usefulness to obstetrical and gynecological practice. Following the scientific program, Dr. West discussed some of the problems and misunderstandings that exist between the neighbor island societies and the HMA. It was voted to submit a resolution at the forthcoming House of Delegates' meeting to change the system of making nominations from the floor.

* * *

There were 18 members present at the September 30 meeting held at the Hilo Hotel. Dr. Robert Miyamoto reported on the interim session of the House of Delegates and advised that the Society's resolution be introduced and referred to the HMA Bylaws Committee. Dr. Bracher reported that a donation to the Scholarship fund of stocks worth approximately $2,800.00 had been made by Mr. William Middleton of Honolulu.

* * *

A short business meeting was held on October 24 to select a nominating committee. It was voted to invite members of the Peace Corps to attend the Society's annual Christmas Party. Following dinner, HMA's PR Committee Chairman, Dr. Ivy, discussed the work and scope of his committee.

* * *

The November 24 meeting was held at the Hilo Hotel. A letter from the HMA's Public Relations Committee was discussed wherein the suggestion was made to hold meetings in the area of the Honolulu airport in order to accommodate neighbor island members. The Secretary was asked to advise the HMA that the Society looks upon this arrangement favorably.

A committee was appointed to look into the problems connected with the Department of Social Services and Government Physicians. Members are Drs. Miyamoto, M. H. Chang, Wipperman, and Henderson. It was voted to write to the Attorney General and ask for authorization to rent the EKG machine which is at present for use only by the Department of Social Services.

Dr. Waltman Walters spoke on pancreatitis and castric carcinoma.

Honolulu

There were 231 members and guests present at the October meeting. The following new members were in-

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HAWAII MEDICAL JOURNAL

Notes and News

New Offices for . . .

Dr. Yan Tim Wong, practicing psychiatry and neurology at 1163 South Beretania St.

Dr. James B. H. Young, in urology at 252-A Alexander Young Bldg.

Dr. Francis T. Oda, practicing general surgery at 1407 Kalakaua Ave.

Drs. John H. O. Kim, endocrinologist, and **Lawrence Lit Lau, Jr.,** general practitioner, associated with the Hawaii Permanente Medical Group. Dr. Lau will be in charge of the Maili clinic.

Dr. Dudley S. J. Seto, in internal medicine at 205 South Vineyard St.

Dr. William O. Kirker, to be associated with **Dr. James G. Marnie,** at 1313 South Beretania St.

Dr. Norman Y. Nakamura, in orthopedic surgery at the Ala Moana Bldg., 1441 Kapiolani Blvd.

Dr. Fumio Sugimoto, practicing general medicine at the Leeward Medical Center, Aiea.

Relocations

Dr. Willard Y. Miyahira—to the Central Medical Clinic, 1481 South King St.

Dr. Joseph Finney—to the University of Kentucky, to teach psychiatry at the medical school. (Before going he denied the statement that "Hawaiians lack ambition." He only reported what other groups in Hawaii said.)

Dr. Raymond G. Chang—to the Professional Center Annex, 1481 So. King St.

Drs. Calvin C. J. Sia and **Sorrell H. Waxman**—to the Children's Medical Clinic at 1350 South King St. **Dr. Frances Nakamura,** pediatric cardiologist, has joined them at this address.

Dr. Carolina Dizon Wong—to 1744 Liliha St.

Health Tips in the Press

Dr. William F. Moore, Jr., chairman of the Message of the Month Committee, made the *Star-Bulletin* with tips on how to quit smoking; e.g. chew gum, keep busy, take brisk walks, avoid coffee breaks, etc.

Dr. Frank Tabrah's HMJ paper on the dangers of high school football drew a protest from **Drs. James Marnie** and **Thomas Y. K. Chang.**

Free screening tests for diabetes have moved to Neighbor Islands this year—Maui and Kauai, so far. The HMA committee, headed by **Dr. Louis G. Stuhler,** works with **Dr. Doris Jasinski** and Nursing Consultant **Harriet Kuwamoto**, of the Department of Health's Chronic Disease Branch. The test is based on a two-hour postprandial finger tip blood specimen. All specimens below 130 mg% of blood sugar register negative.

Dr. Ira Hirschy of the State Health Department warned Hawaii's residents of the liver fluke danger from eating wild watercress. A 1956 report recorded 19 cases diagnosed in Hawaii, with one death. Commercial watercress is safe.

Sad Notes

Condolences to **Dr. Fred K. Lam** and family on the loss of their daughter, Jeanette, who was a hard working health educator in our State Health Department.

Dr. Robert Ruff, onetime director of medical education at St. Francis, died while undergoing heart surgery at St. Vincent's Hospital in Los Angeles.

Condolences to the family of **Dr. Arthur L. Davis,** who was the Waialua Plantation doctor from 1926 to 1952. He died at Queen's several weeks ago following an operation for a brain tumor.

Drs. Clarence E. Fronk and **Masato Hasegawa** must have shed a few tears when the polo and riding academy stables were finally removed from Kapiolani Park.

Sad for Queen's Hospital was a suit filed for damages of over $1 million by **Dr. E. Wonsik You.** He charges that **Will Henderson,** Queen's administrator, barred him from administering anesthetics to the patient of another doctor.

Happy Notes

Judith, daughter of **Dr. and Mrs. Raymond Eklund** of Kamuela, Hawaii, was married to Martin Greer Pawley of Arlington, Virginia, in December at the Kamuela St. James Episcopal Church. The newlyweds plan to return to college to complete their education.

Dr. Walter Herter rated a full page recently in *Consultant* for his invention, which weighs small kids and makes them like it. The scale boasts a T-bar set in a pipe flange screwed to the moving scale platform, and resembles a scooter.

The wedding for Tom Giles, son of **Dr. Fred L. Giles,** to the former Leslie Paul, niece of **Dr. Rodney T. West,** was attended by their many friends, with much champagne.

The **Drs. Mertz** are parents of their fourth child, third girl, Amy Malia, who was born August 17.

A local columnist quoted the story about a young specialist who, after listening to a dowager patient bemoaning the disappearance of the good old family doctor, came out with "Madam, if you will show me an old-fashioned family, I'll be glad to produce a doctor for it."

Construction plans will go into full gear next summer on a $2.5 million expansion of the facilities at Shriners' Hospital for Crippled Children. This will double their present 30-bed capacity.

Medical Training

Cardiovascular disease will be the theme for the next annual HMA meeting, scheduled for the Princess Kaiulani Hotel, April 29 through May 3. Guest speakers will include **Drs. Thomas Starzl** of Denver, **Irvine Page** of Cleveland, **John J. Kelly,** and **Frank Gerbode,** both of San Francisco.

Whether you happen to be a surgeon or not you should not have missed the Pan-Pacific Surgical Conference, held here in November. Participants included **Sir John Bruce,** one of the surgeons to the Queen of England; **Dr. Alton Ochsner; Dr. Albert Starr,** of Starr valve fame; **Dr. Viking Bjork,** who among other things made a hit on the HMA's TV show in a Viking helmet and beard; **Dr. Frank Gerbode; Dr. Donald Effler,** and **Dr. Irving Stein,** of Stein-Leventhal syndrome fame. **Dr. R. Frederick Shepard** was the only local doctor to speak at the Conference. New president is **Dr. Enrique M. Garcia,** of Manila.

A five-day dermatology conference held at the Hawaiian Village Hotel in September attracted about 200 doctors. **Dr. Donald Birmingham** of Cincinnati pointed

out the severe skin irritant properties of Epoxy cement. **Dr. George L. Fite** of Carville, Louisiana, showed how the fibrous coating of nerves could be excised to relieve pain in Hansen Disease patients. **Dr. Edward Ringrose,** President of the Pacific Dematologic Association, noted the relationship between heavy smoking and certain skin eruptions and mouth lesions, as well as cancers of the oral cavity. The only nontechnical paper of the session was read by **Dr. Harry Arnold, Jr.** He read aloud the blistering attack by Robert Louis Stevenson on a Honolulu churchman who had criticized Molokai's Father Damien.

Medical Training Courses

A course in Laryngology and Bronchoesophagology will be given by University of Illinois College of Medicine faculty, March 16 through 28, under the direction of **Dr. Paul H. Holinger.** Registration will be limited to 15 physicians. For further information, write the University at 1853 West Polk St., Chicago 60612.

Scripps Clinic & Research Foundation will conduct a nine-month course in cardiology starting September 15, 1964, at La Jolla. For further information write to **Dr. E. Grey Dimond,** Scripps Clinic, La Jolla.

Hawaii Academy of General Practice and the Lederle Company sponsored a symposium in September. The main speakers were **Drs. Jones B. Donaldson,** Clinical Professor at Temple; **Beverly T. Mead,** Assistant Professor Medicine at the University of Kansas Medical Center.

Here's hoping the Hawaii Heart Association can give us more sessions like the last one of October 31–November 2 at which **Drs. James V. Warren, John J. Sampson,** and **B. L. Martz** presented their views on heart disease.

Drs. Paul Gebauer, Bernard Yim, Carl Mason, and **David Preston** presented interesting papers at the Hawaii Thoracic Society's regular quarterly meeting at Leahi Hospital in October. A few days later Dr. Gebauer left for a circuit through South America to give his paper on bronchial grafts constructed from skin.

Drs. Unoji Goto, Carl Mason, and **Richard Chong** spoke on tumors, open heart surgery, and the freezing technique in treatment of ulcer at the Hawaii Nurses Association annual meeting on October 10.

Dr. Doris Jasinski led a training session on mouth-to-mouth resuscitation and external heart massage for the Honolulu County Medical Society Auxiliary and representatives of other community organizations. An excellent film, "The Pulse of Life," was shown and practice carried out on Resusci-Anne.

Dr. Frances Cottington gave a talk to the University of Hawaii's Preschool PTA on "The Problems of the Gifted Child."

Placement Service

The Pearl Harbor Shipyard Dispensary is looking for a full-time physician. Hawaii license not necessary. Call Mr. Gasper at 430-24130 or write the Industrial Relations Department.

Positions vacant in the Health Department include: TB Physician, Alcoholism Physician, Civil Defense Medical Consultant, and Chronic Disease Physician.

General practitioners are needed for Canton Island and Samoa, Kwajalein, and Johnston Island.

Vacancies are still open in the medical, surgical, OB, and pediatric residences of the major Honolulu hospitals. Don't forget, the stipend has been raised to a minimum of $550 a month.

The Peace Corps has announced that it will need many doctors, dentists, nurses, x-ray technicians, sanatarians, etc., to meet requests of host country governments in 1964. For more information an application, write to: Peace Corps, Division of Recruiting, Washington, D. C., 20525.

Hawaii Department of Health

COMMUNICABLE DISEASES IN HAWAII
September–October 1963

DISEASE	SEPT. 1963	OCT. 1963	NOV. 1963	FIVE-YEAR MEDIAN
Brucellosis	—	—	1	—
Chickenpox	45	41	32	106
Conjunctivitis Infectious	—	2	3	1
Dysentery Amebic	—	—	1	—
Dysentery Bacillary	1	22	26	10
Gonorrhea	22	22	27	19
Hansen's Disease	1	1	2	1
Hepatitis Infectious	1	4	3	3
Hookworm Disease	—	1	1	—
Influenza	16	46	67	40
Measles	20	26	11	58
Measles German	1	1	—	10
Meningitis Meningococcic	—	4	4	1
Mononucleosis	1	—	—	—
Mumps	64	106	129	73
Pneumonia Infectious	7	4	3	19
Rheumatic Fever	—	2	—	—
Salmonellosis	26	29	54	16
Scarlet Fever	2	9	4	4
Streptococcic Sore Throat	132	600	304	8
Syphilis Late	7	4	8	6
Syphilis Early Latent	2	2	1	1
Syphilis Primary & Secondary	—	—	1	
Weil's Disease	3	5	1	—

COMMENTS

1. Neisseria Meningitidis was the organism isolated from the case resulting in the recent death of a high school student in six hours.

2. The high incidence of reported Strep throat in September and October is the result of a special study by the Air Force. It does not necessarily follow that there is an epidemic.

3. The increase in Salmonella may be one result of greater effort in followup of contact investigation. Fourteen of these cases were found at one activity.

Names in the News

Dr. Casimer Jasinski has left his position as Civil Defense Medical Consultant for a residency in internal medicine at St. Francis Hospital and to write this column. He hopes HMA readers will like this version of Notes and News when editors McCaslin, Jasinski (D.) and Arnold get through with it.

Dr. Lawrence Winter has resigned as Alcoholism Physician for the Health Department to enter private practice in Honolulu.

The Queen's Hospital open-heart surgery team permitted *Advertiser* reporter Bob Jones to watch them in surgery. A half-page article called "I Saw a Live Heart in a Doctor's Hand" appeared shortly thereafter. What the doctors were not prepared for was the unauthorized use of their names.

Dr. Hans Graumann got his new x-ray equipment and a red face when the firm who sold it announced its use in the paper without consulting him.

Tall, trim, vigorous **Dr. Henry N. Harkins,** Professor of Surgery at the University of Washington School of Medicine, concluded a lively month of lectures in the visiting professor program sponsored by Queen's, St. Francis, and Kuakini hospitals. The next visiting professor to Hawaii will be **Dr. Frederick C. Robbins,** Associate Professor of Medicine at the University of California at Berkeley and **Dr. William Analyan,** from Duke.

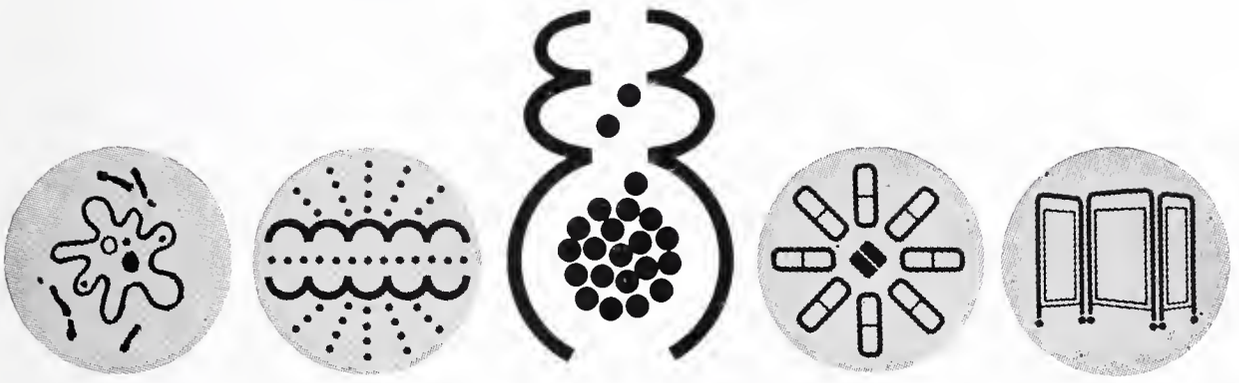
Drs. James Harrison, H. Q. Pang, and **I. A. Kawasaki** were members of Hawaii tour groups to Russia and Europe last summer. The tours were well reported by

continued page 230

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Gastroenteritis | Functional diarrhea | Drug-induced diarrhea | Postsurgical diarrhea

Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE



it's a long way back to the barn...

It's a long road to almost *anywhere* for anyone suffering the excruciating, itching discomfort of *pruritus ani.* ARISTOCORT Triamcinolone Acetonide Cream is highly active against the embarrassing and intolerable irritation of pruritus ani and vulvae. Sparing application to the affected area—3 to 4 times daily—usually provides rapid relief. And when excoriation of the area has led to infection, the choice of NEO-ARISTOCORT Neomycin Sulfate-Triamcinolone Acetonide will assure activity against a wide range of skin pathogens. A possible side effect may be local skin sensitization due to neomycin. Contraindications (both forms): tuberculosis of the skin, herpes simplex, and chicken pox. Prescribe tubes of 5 or 15 Gm. Also available in ½ lb. jars.

Aristocort® TOPICAL CREAM 0.1% AND OINTMENT 0.1%
Triamcinolone Acetonide

Neo-Aristocort® CREAM 0.1% AND OINTMENT 0.1%
Neomycin Sulfate (0.5%)—Triamcinolone Acetonide (0.1%)

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246-3

HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: JAMES YANO, Kaiser Foundation Hospital

The Profession of Medical Technology

The "learned professions" have been historically theology, medicine and the law. An individual, to serve with distinction in any of these professions, needs not only intellect and training, but also must possess the professional attitudes of devotion, service, and dedication. Since medical technology is an integral part of medicine, it is logical and proper to classify medical technology as a profession.

The importance of medicine and its influence on modern society is unquestionable. The ever-expanding knowledge and techniques increase daily and with them the complexities and intricacies. It is almost impossible for any individual to comprehend all phases of medical knowledge, let alone be an expert in his chosen specialty.

With this growth came the need for a new branch of medicine, clinical pathology; subsequently, with its growth, came the development of the profession now known as medical technology.

What is, then, a medical technologist and how does one become a medical technologist? What qualifications and requirements must a person possess in order to be considered a candidate for the registry examination by the American Society of Clinical Pathologists? What does the future offer?

The medical technologist is a person "who, by education and training, is capable of performing, under the supervision of a pathologist or other qualified physician, the various chemical, microscopic, bacteriologic and other medical laboratory procedures used in the diagnosis, study and treatment of disease." Although most of the duties and responsibilities delegated to the medical technologist are "behind-the-scene" activities, nonctheless, he plays an integral and important part in the field of diagnostic medicine. In his skill and integrity may rest the life of another.

The demands and needs of bigger and better diagnostic laboratory facilities are increasing. The consequent demands and needs for better, more qualified, and more dedicated medical technologists to provide this vital service must be fullfilled.

AN IDEAL CANDIDATE

An individual who is keenly interested in science, who has a desire to be of service to humanity, who is of highest intellect, integrity, and understanding, and who is dedicated to and conscious of responsibilities, but who is not after fame, fortune, glamour or glory, would be an ideal aspirant for medical technologist. Any person who possesses some of the attributes stated above in any combination or to any degree would make an excellent candidate.

Since 1962, the educational requirements to a school of medical technology, approved jointly by the Council of Medical Education and Hospitals of the American Medical Association and by the American Society of Clinical Pathologists, are three years (90 semester hours or 135 quarter hours) of collegiate work in any college or university accredited by a recognized standardizing association. The three years must be acceptable towards a baccalaureate degree. During the three years, a minimum of 16 semester hours (24 quarter hours) of chemistry, 16 semester hours of biological sciences and one semester of college mathematics are minimum requirements. When the internship during the senior year in a approved hospital school affiliated with a college or university is integrated with the university program, such training can be credited towards a baccalaureate degree in medical technology.

UH PROGRAM

At the University of Hawaii, a four-year program leading to a Bachelor of Science degree in medical technology is offered in the College of Nursing under the chairmanship of Dr. John T. Nasse, Jr. and Mrs. Louise Wulff, Instructor of Medical Technology.

Dr. Nasse received his B.A. degree from Wesleyan University in Connecticut in 1956 and his Doctor of Medicine degree from McGill University in Montreal, Canada in 1960. He served his internship period at St. Francis Hospital in Honolulu during 1961 and sinee then he has been chairman of the department of Medical Technology and assistant professor in the department of zoology. During the past two years, he has attempted to further integrate the programs of the approved hospital schools of Kaiser, Kuakini, Queen's, St. Francis, and U.S. Army Tripler Hospitals with the pre-internship curriculum at the University with



the approval of a new instructorship position on the University faculty.

Mrs. Louise Wulff became the first registered medical technologist to be on the university staff as an instructor. She received her degree and training at the University of Wisconsin. For several years, Mrs. Wulff worked as a research technologist on cancer and kidney problems before moving to Fitzimmons Hospital in 1941. During World War II, she went overseas with the 199th General Hospital which served in England and France. At the end of the war, she came to Hawaii with the Army Red Cross unit. Since 1946, she has served with the Hilo Memorial Hospital, the State Board of Health, and since 1952 until her recent appointment, at the Hawaii State Hospital. She is past president of the Wisconsin and Hawaii Societies of Medical Technologists.

Her present course at the University of Hawaii is designed specifically for the junior students. An introduction to the application and theory involved in basic laboratory practice, it emphasizes the role of the medical technologist, the nature of his work, and a glimpse into the future for a member of a dignified profession.

1964 INTERNS

Upon satisfactory completion of the junior year, the following students will be interns during 1964: Patricia Dennis, Janice Fujiwara, Clarie Fukushima, Takeko Iha, Eleanor Kamada, Noreen Kawamura, Irene Matsuo, Ethel Naito, Judith Nitta, Vicky Nojima, Roy Ohye, Jean Otake, Leah Taga, Stanley Tagawa, Marian Takehara, Irene Teruya, and Lillian Uemori.

"All graduates of approved schools of medical technology become eligible, and are expected to take the examination for registration given by the Board of Registry of Medical Technology of the American Society of Clinical Pathologists. Until a graduate has passed this examination, he is not entitled to use the designation MT(ASCP) after his name. Registry examinations are given twice annually. Application forms are available from the Registry of Medical Technologists, P. O. Box 44, Muncie, Indiana." Application fee of $20 must accompany proper enclosures. A renewal fee of $2.50 is necessary to renew registration and certification.

SPECIALTY CERTIFICATION

"In addition to certification of medical technologists, the Registry certified specialists in medical technology who have more advanced training in their respective fields. Finally, limited certificates are issued for some subdivisions, such as chemistry, microbiology, blood bank procedures, histologic technic and exfoliative cytology."

With the shortage of medical technologists in recent years, a new qualification of college-plus-experience for admittance to the examination have been announced by the Registry. The new qualifications will permit any college graduate with five years of experience in a clinical laboratory, two years of which must have been under the direction of a pathologist, and who has met the present requirement in chemistry, biological sciences, and mathematics be made eligible for the Registry examination for certification.

Each registered medical technologist, MT (ASCP), who is interested to "promote higher standards in clinical laboratory methods and research" is asked to be a member of the American Society of Medical Technologist (ASMT) and his own local state society. Application fee for membership in both the national and state society together is $15.00 per year. A member of the ASMT and the Hawaii Society of Medical Technologists (HSMT) receives published papers on the latest developments in medical technology, the "American Journal of Medical Technology," the ASMT News Release, the Hawaii Medical Journal, and in addition, is eligible to vote and hold state or national offices within the organization. Above all, members become active participants in the growing field of Medical Technology.

The future of medical technology appears bright and challenging. The demand for good and capable medical technologists will be great for many years to come, while the salary will be steadily increasing. Personal recognition and pride in this profession, coupled with hard work, patience, understanding, and initiative, will add further to strengthen our position as medical technologists, a branch of the profession of medicine.

JAMES R. YANO
Editor

The book concludes with a final examination and answers as a guide to how much one knows about diabetes before or after reading it.

RAYMOND M. DEHAY, M.D.

★Bone Changes in Hematologic Disorders (Roentgen Aspects)

By John E. Moseley, M.D., 261 pp., $9.50, Grune and Stratton, 1963.

THIS BOOK is well-illustrated. The discussion of the various diseases manifiesting bone changes is a credit to the author. He has given a brief description of each disease from the standpoint of its etiologic significance and clinical manifestations, without boring the reader with details. Of particular interest is the section on the anemias. The reader will realize that there are characteristic changes in the various types of anemias and that this may be of diagnostic aid; i.e., aseptic necrosis of the head of the femur in Hgb S-C Disease.

The only point of some confusion in this text lies with the arrangement of the description and corresponding illustrations. This is probably inevitable because of the large number of illustrations, but frequently the reader must thumb three to four pages ahead to look at the illustration which is being described. Despite this, this book is recommended highly.

NOBORU OISHI, M.D.

Foundations of Anatomy and Physiology

By Janet S. Ross, R.G.N., R.F.N., and Kathleen J. W. Wilson, B.SC., R.G.N., S.C.M., 451 pp., $7.00, The Williams & Wilkins. Company, 1963.

AN INTRODUCTORY TEXT should be as free of error as possible. I have no quarrel with the subject matter since it represents a concise, superficial review of anatomy and physiology for student nurse, which is the intention of the authors. There are several typographical errors (pertous, for petrous, p. 39; obdurator, for obturator, p. 63; latismus, for latissimus, p. 202, etc.). For clarity a number of the line drawings (particularly of bones) should have been labeled more completely, while a couple (p. 64 and p. 216) are mislabeled. The color plates of blood cells are abominable.

Perhaps, if this book survives to a second edition, both the editors and the authors will correct the many small errors which must be frustrating as well as confusing to the novice in her first course in two difficult subjects.

GEORGE F. PARKER, M.D.

External Infections of the Eye—Bacterial, Viral and Mycotic

By Helena Viantovoskaya Fedukowicz, 220 pp., $16.50, Appleton-Century-Crofts, 1963.

THIS IS A MODERN, English treatise on ocular infections including laboratory diagnosis and treatment. It is well written.

The treatise on bacteriology, while good, seems too simplified and basic for a modern-day ophthalmologist, but the section on virology is excellent and one of the best that I have reviewed.

The photography could be improved, and the color plates are misleading in many cases. They are not, in my opinion, true representations of actual laboratory and clinical findings.

This volume is worthy of study and makes an excellent reference particularly for virological cases. The short paragraphs devoted to "treatment" could have been omitted due to their terseness and the obvious outdated status of treatment in general.

PHILIP M. CORBOY, M.D.

Medical Laboratory Technology

By Matthew J. Lynch, M.D. (N.U.I.), M.R.C.P. (Lond.), F.C.A.P., Stanley S. Raphael, M.B., B.S. (Lond.), Leslie D. Mellor, L.C.S.L.T., F.I.M.L.T., Peter D. Spare, F.I.M.L.T., Peter Hills, L.C.S.L.T., F.R.M.S., and Martin J. H. Inwood, L.C.S.L.T., F.I.M.L.T., 735 pp., $12.00, W. B. Saunders Company, 1963.

THE BOOK is well organized and presents material clearly and concisely. The charts and diagrams support the text and the illustrations are good. I believe that physicians interested in laboratory medicine and technologists will find this book a helpful reference.

PAUL Y. TAMURA, M.D.

Synopsis of Ear, Nose, and Throat Diseases, 2nd Ed.

By Robert E. Ryan, B.S., M.D. (ALR), F.A.C.S. William C. Thornell, A.B., B.M., M.D., M.S. (ALR), F.A.C.S., and Hans von Leden, M.D., F.A.C.S., F.I.C.S., 425 pp., $7.50, The C. V. Mosby Company, 1963.

THIS BOOK is a handy guide for the busy family physician and the synopsis represents a digest of the common ailments within the specialty. Many changes have taken place in otolaryngology, especially in constructive surgery. Each part of the book begins with a concise review of the clinical anatomy and physiology; and each chapter ends with an outline summary where the subject matter may be studied easily. The chapter on microsurgery of the ear explains the new terminologies such as tympanoplasty, myringoplasty, and stapedectomy; the chapter on headaches is informative; emphasis is places on early diagnosis, conservative surgery and rehabilitation of defects and function.

The authors, all former Fellows of the Mayo Clinic, have limited themselves to essential matters and have fulfilled their purpose.

TADAO HATA, M.D.

Personnel in World War II

Editor in Chief, Colonel John Boyd Coates, Jr., MC., USA, Medical Department, United States Army, Office of the Surgeon General, 548 pp., $6.00, U.S. Government Printing Office. 1963.

THIS IS A detailed volume of how the Army Medical Department was expanded, starting in 1939, when our country began its mobilization for World War II. It also goes through 1946 and the demobilization phase. Mixed in with the numerous tables of statistics are answers to many of the complaints heard during this time. Few knew of the running battle that continually went on between Procurement and Assignment and the Surgeon General; of the unsuccessful efforts to institute a doctor draft. Answers are given as to why faithful reservists were given lower ranks than men fresh in from civilian life. This is a rather interesting book on a subject that would be expected to have a limited appeal to anyone not directly involved in the Army Medical or Nursing Corps during this time.

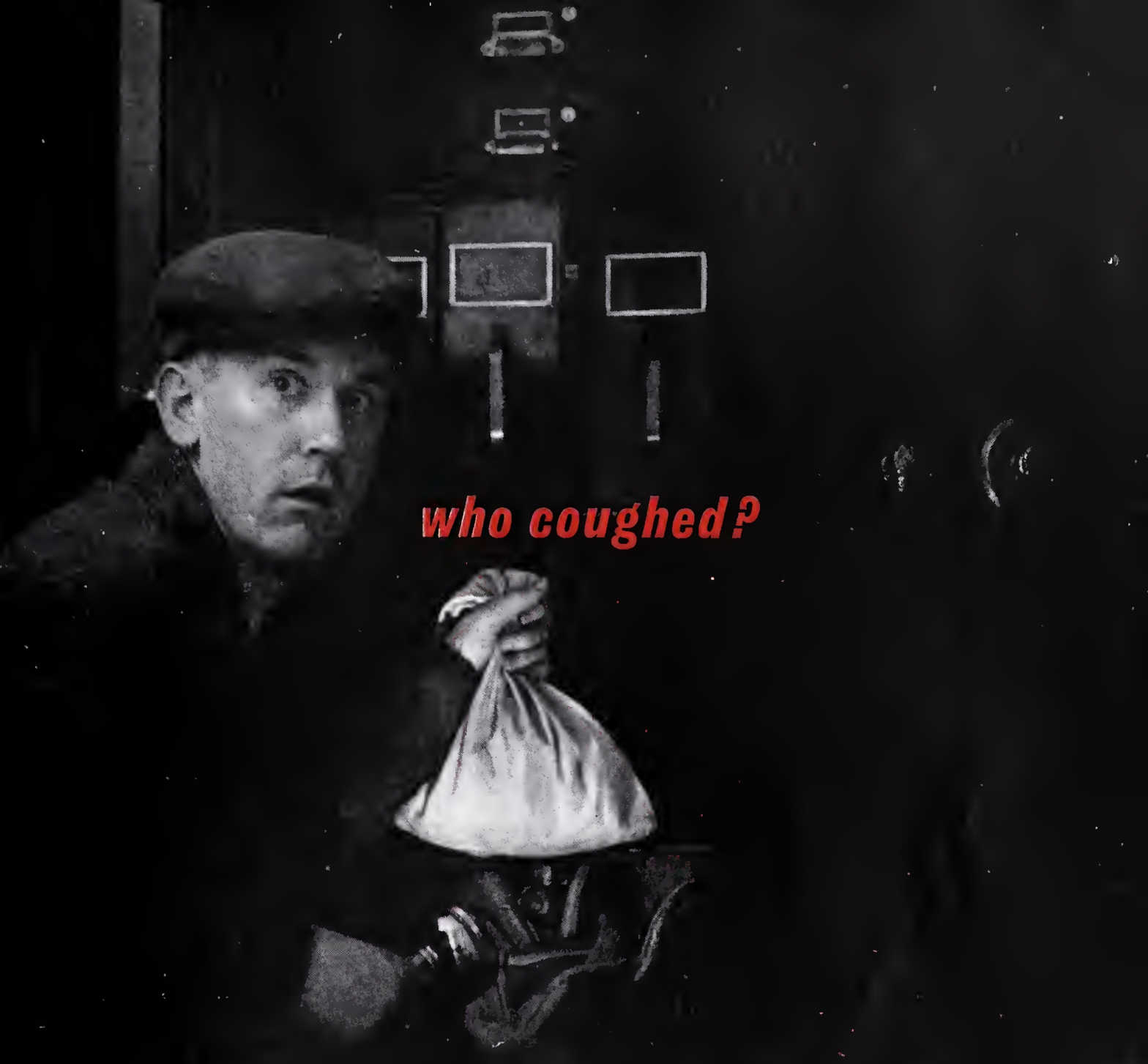
RAYMOND M. DE HAY, M.D.

★A Doctor Discusses Pregnancy

By William G. Birch, M.D., with Dona Z. Meilach, Ph.B., 114 pages, $1.50 to patients, distribution exclusively to physicians; complimentary copy available gratis on request (on letterhead) to Professional Service Dept., Budlong Press, 5428 N. Virginia Ave., Chicago 60625

THIS IS probably the best patient's booklet on pregnancy, prenatal care, delivery, and postnatal care that I have read. It is difficult to write such a booklet which covers the subject so tactfully and so thoroughly and which is still suitable for the patients of both the general practioner and specialist. The one thing which I take exception to is the continued recommendation of the "knee-

continued page 224



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Reports & Snorts

"Paget's disease" may soon refer exclusively to mammary ductal adenocarcinoma metastatic to the epidermis of the nipple and areola—the original "epithelium." Even the 1957 edition of Dorland, though it lists osteitis deformans as the first meaning of "Paget's disease," and the breast lesion as the second, does not mention "Paget's" under the definition of osteitis deformans; and the 1964 edition of *Current Medical Terminology* mentions under "PAGET [*sic*] DISEASE" only one kind: "OF BREAST."

• • •

Editorial style is each individual editor's own business, but editors try for some degree of agreement and uniformity. Some presses (University of Chicago, for example) publish their own "style books." Now the AMA has taken a large step out front with its own style book, the second edition of which has just been issued. You'll see its impact in future issues of JAMA, *of course. For instance, though periods are still used with Mr., Jr., St. (Saint, not Street!), No., Rev., Hon., and Dr., they have been eliminated from all all-capital abbreviations, including MD, AMA, and US, and from all all-lower-case ones too, including mm, cm, cc, min, sec, and in; they have also been eliminated from all abbreviations of military and academic rank, including Prof, Gen, Lt Col, and all the rest.*

• • •

NegGram (nalidixic acid) is reportedly highly effective against B. proteus, E. coli, and A. aerogenes, as well as some strains of Pseudomonas (J. Urol. 90:476, 1963).

• • •

Krebiozen has been found by the FDA, from a 2-mg sample furnished by Drs. Ivy and Durovic, to be pure creatine monohydrate. Mysteriously, they also report that Krebiozen ampoules distributed prior to 1960 contained only pure mineral oil, without any creatine or creatine derivative. Ampoules obtained in 1963 contained 0.05 to 0.4% amyl alcohol and 2 to 12 micrograms of 1-methylhydantoin, a creatine derivative.

An amusing sidelight, with some possible sinister significance, is HEW's contemptuous dismissal of Dr. Durovic's original empirical formula for Krebiozen—$C_{67}H_{25}O_{19}N_{18}$—as "bearing no relation to" the empirical formula of creatine: $C_{11}H_4O_3N_3$. Try dividing it by six and you'll find it's a CHO off!

Nouns *cannot* be used as adjectives, says Alexander Gode in last November 16's *JAMA*. This is an entirely different statement from Morris Fishbein's old familiar dictum that nouns *should* not be used as adjectives.

Fishbein's pet "horrible example" was the headline on an article telling of the trouble in choosing a captain for the English cricket team: ENGLAND ELEVEN CRICKET CAPTAIN SELECTION DIFFICULTY. Dr. Fishbein always insisted on turning nouns into adjective forms—e.g., not skin cancer, but cutaneous cancer; not sinus orifice, but sinal orifice.

Gode's point is dazzling in its perceptiveness and simplicity. Adjectives, he points out, have comparative and superlative degrees; can be modified by adverbs; and can be linked to the noun they modify by simple copulative verbs (e.g., the car is red). Nouns in what seems the position of an adjective have none of these characteristics, from which Gode argues that they are not adjectives at all but merely parts of newly formed compound nouns.

You don't have to say hepatic necrosis—you can say liver necrosis. If you do, however, you have not, as Dr. Fishbein thought, used liver as an adjective. (If you had, you'd be able to say "the necrosis was liver," just as you could say "the necrosis was hepatic"). You have merely created a new compound noun.

English has inherited this useful and expressive process from German; it can't be done in French. Don't avoid it, Gode wisely urges; especially, don't avoid it just because you think a noun should not be used as an adjective!

• • •

Ames makes "Pheniplate" for biological identification of phenylalanine in blood by its enhancement of germination of B. subtilis spores.

• • •

By a new technique involving plasmapheresis, cells from donated blood can be returned to the donor within 15 minutes, keeping only the plasma. The lost plasma is replaced by the body within 24 hours, so a single donor can furnish as much as a quart a week. ■



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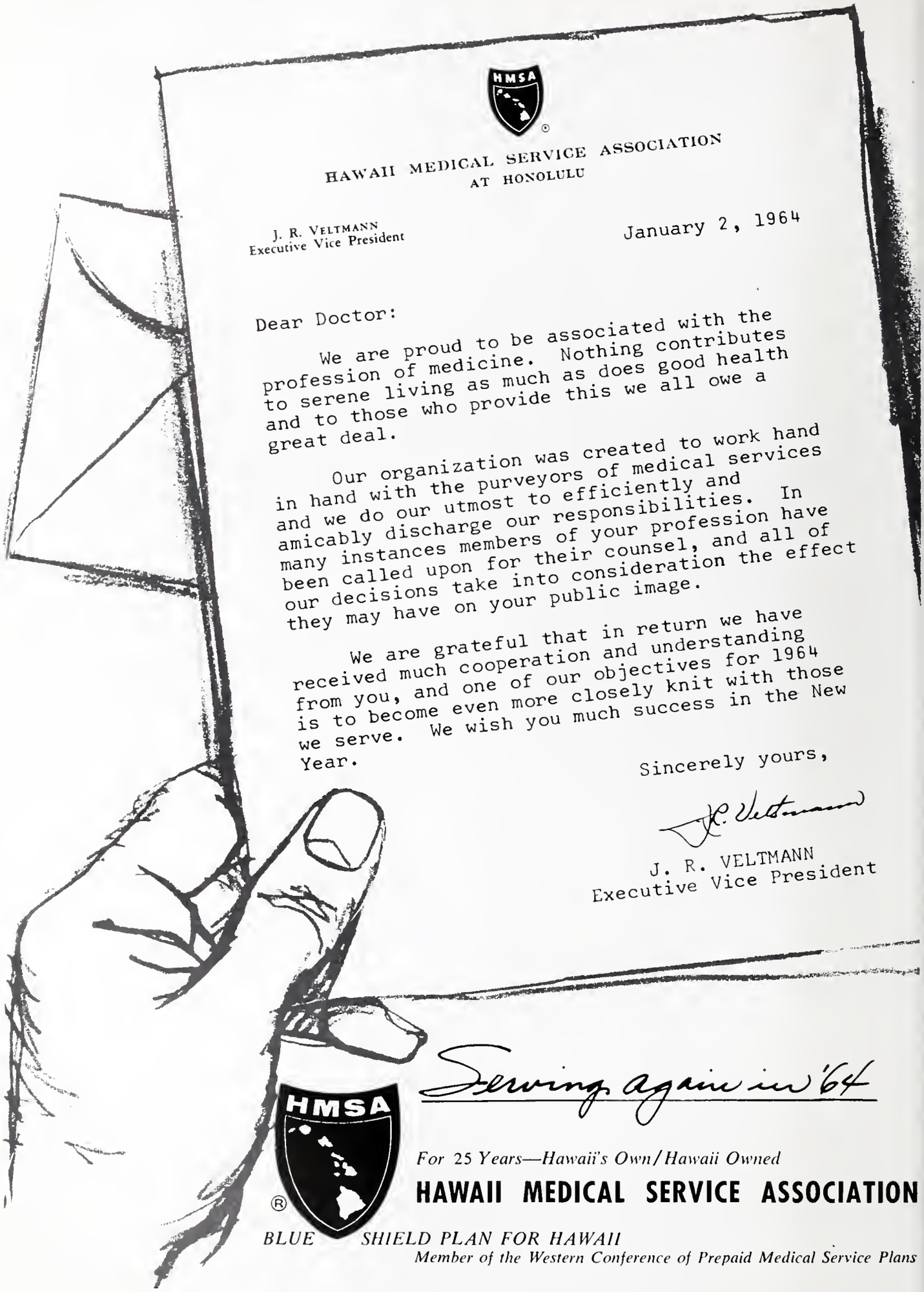
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January 2, 1964

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Our organization was created to work hand in hand with the purveyors of medical services and we do our utmost to efficiently and amicably discharge our responsibilities. In many instances members of your profession have been called upon for their counsel, and all of our decisions take into consideration the effect they may have on your public image.

We are grateful that in return we have received much cooperation and understanding from you, and one of our objectives for 1964 is to become even more closely knit with those we serve. We wish you much success in the New Year.

Sincerely yours,

J. R. VELTMANN
Executive Vice President

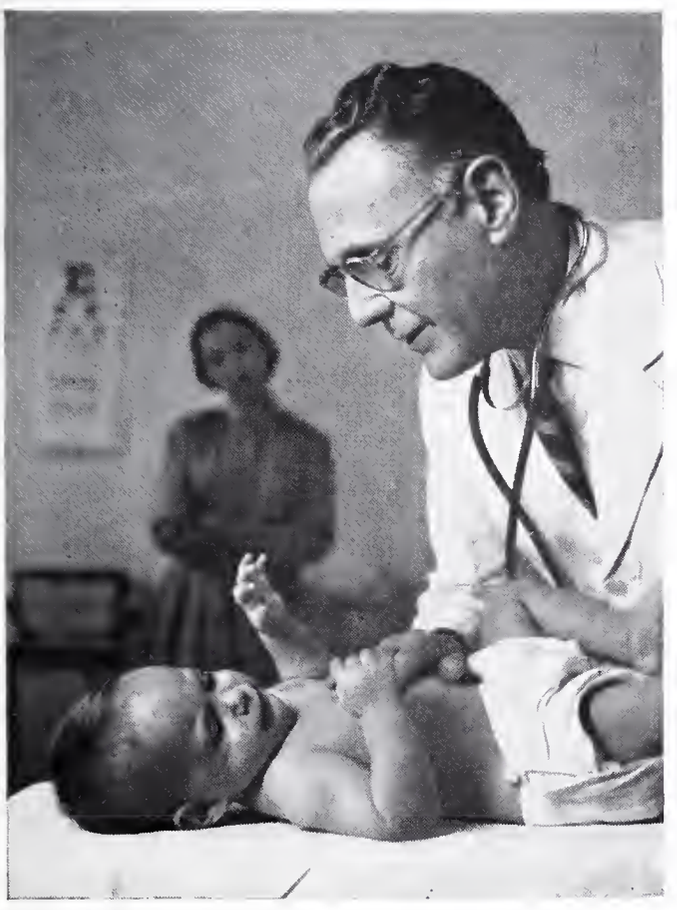
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References: 1. Wilson, J. F.; Heiner, D. C., and Lahey, M. E.: J. Pediat. 60:787, 1962. **2.** Committee on Nutrition, Collected Reprints, 1956-1962, Evanston, Ill., American Academy of Pediatrics, 1963, p. 45. **3.** Beal, V. A.: Pediatrics 20:448, 1957. **4.** Reisner, E. H., Jr.: Penn. Med. J.: 63:49, 1960. **5.** Marsh, A., et al.: Pediatrics 24:404, 1959.

M & R Dietetic Laboratories Inc.
Columbus 16, Ohio

chest" exercise for postpartum patients. Other than this, I would recommend this book for the routine obstetrical patient.

R. T. West, M.D.

The Electrocardiogram and Chest X-Ray in Diseases of the Heart

By Arthur M. Master, M.D., Richard P. Lasser, M.D., Isadore Rosenfeld, M.D., and Ephraim Donoso, M.D., 565 pp., $21.00, Lea & Febiger, 1963.

The authors state in the preface of this volume that it "is not intended to replace the conventional textbooks of electrocardiography but rather to supplement them with a wider and more intimate synthesis of the major diagnostic modalities." Certainly they have been very successful in accomplishing their purpose. To the cardiologist this book is pleasant to read and full of pertinent and interesting illustrations of chest x-rays, electrocardiograms, angiocardiograms, and occasional vectocardiograms.

The book is divided into sections according to the various etiologies of heart disease. The congenital heart diseases are listed according to Taussig's classification, a commonly used one.

Some particularly valuable features are the discussion of the vectorcardiogram and its use in clinical heart disease, the simple definition of "systolic and diastolic" overload of the heart, and the discussion of criteria of diagnosis of cardiac chamber enlargement by electrocardiogram and vectorcardiogram. Another feature particularly impressive in this cardiologic textbook is an adequate definition, finally, of what constitutes a true posterior-wall myocardial infarction.

Some of the disadvantages of the book should be mentioned: The electrocardiographic axes mentioned frequently throughout the book are not always the same as those defined by the American Heart Association; the chapter on cardiac catheterization is somewhat short and perhaps too simple in comparison with the level of the rest of the book; and finally, the promise of further development of vectocardiographic examples was not fulfilled in the discussion of case histories.

Nevertheless, the book is well done and fills a definite need in its approach to cardiology; this reviewer would like to have this volume on his shelf.

E. L. Chesne, M.D.

Hernia

By Amos R. Koontz, M.D., 227 pp., $11.95, Appleton-Century-Crofts, 1963.

After having witnessed the repair of hernias, particularly groin hernias, in many hospitals in various parts of the world, I have come to the conclusion that there is no other operation done so poorly by so many surgeons. Most instructors in surgery seem to take it for granted that most anyone can repair such a defect and, therefore, little time is spent on this important and commonly encountered surgical condition. The recurrence rate would indicate that such is not the case. Admittedly, correction of hemorrhoids and hernias lacks the glamour of cardiac surgery, but for the individual beset with these more lowly afflictions it is important to them, at least, that they be treated correctly.

Amos R. Koontz has long been recognized as an authority when it comes to the consideration of all aspects of the hernia problem. His book on this subject is entertainingly written and I have enjoyed reading it from cover to cover. In my opinion, it covers the hernia

continued page 226



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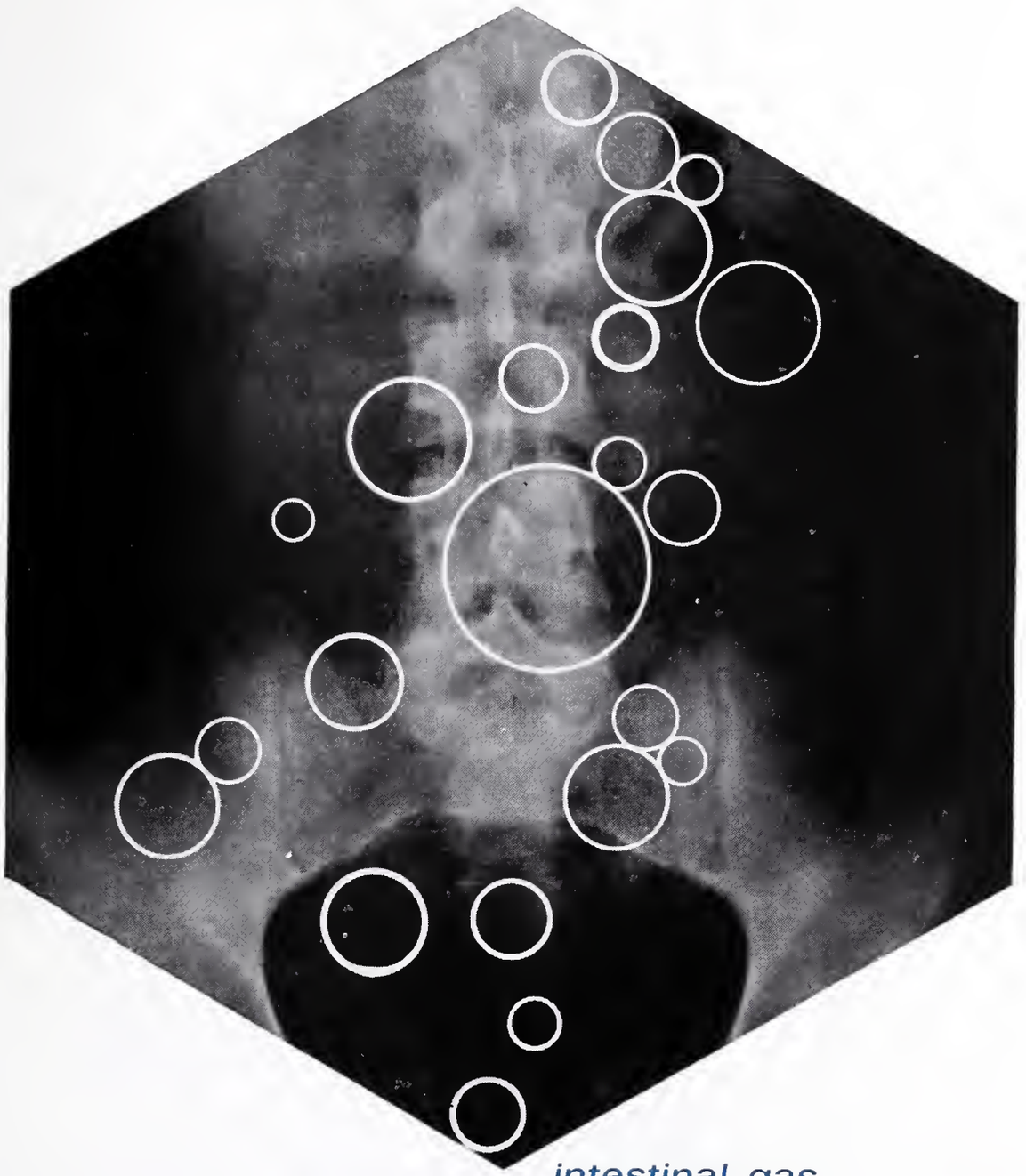
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problem in a most precise, complete, and understandable fashion. Anyone interested in hernia repairs would do well to study the well-done illustrations and practical suggestions embodied in the text.

JOSEPH E. STRODE, M.D.

★Diseases of the Skin, 5th Ed.

By George Clinton Andrews, M.D., F.A.C.P., and Anthony N. Domonkos, M.D., F.A.C.P., 749 pp., $16.50, W. B. Saunders Company, 1963.

THIS NEW EDITION offers a new junior author, a number of full page illustrations, and a more readable format. Andrews, *Diseases of the Skin* has been outstanding in many editions. It is sufficiently detailed and authoritative to be of value to the practicing dermatologist while brief enough to be useful to the medical student or intern. This new edition is practically up to date with the current dermatologic literature, which indicates an unusually cordial relationship between the authors and the publishers. It can be recommended without reservations.

SAMUEL D. ALLISON, M.D.

Also Received

Ciba Foundation Symposium on Transplantation

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., Margaret P. Cameron, M.A., 426 pp., $12.00, Little, Brown and Company, 1962.

RESEARCH level; for the sophisticated reader only.

★An Atlas of Congenital Heart Disease

By Frank E. Sherman, M.D., 303 pp., $15.00, Lea & Febiger, 1963.

BEAUTIFUL DIAGRAMS and photographs; every cardiologist will want to own it, and probably should.

Tropical Therapeutics: Its Pharmacologic Aspects

By Roger A. Lewis, M.D., 276 pp., $11.50, Charles C. Thomas Publisher, 1963.

A JUNGLE doctor's *vade mecum.*

An Introduction to the Science of Human Behavior

By John I. Burnberger, M.D., C. B. Ferster, Ph.D., John Paul Brady, M.D., 379 pp., $5.95, Appleton-Century-Croft, 1963.

"MATURING OBJECT RELATIONSHIPS" and "processes of aversive control" are among the topics discussed.

Handbook of Ocular Therapeutics and Pharmacology

By Philip P. Ellis, M.D., and Donn L. Smith, Ph.D., M.D., 193 pp., $8.50, The C. V. Mosby Company, 1963.

THE DERMATOLOGIC portions are really extraordinarily poor. The recommendations of chlortetracycline and vitamin B_{12} for herpes zoster, Triparanol for xanthelasma, and Nystatin orally for eyelid candidiasis, are three of many more equally bad bits of advice.

continued page 229

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*CLINICAL REPORT ON FILE, MEDICAL DEPT., A.H. ROBINS CO., INC.

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Book Reviews *continued from 226*

Self-Study Guide of Mathematics Used in Nursing

By Geraldine G. Price, R.N., M.S., 65 pp., G. P. Putnam's Sons.

PAPER-BOUND, well printed.

Medical Department, United States Army Organization and Administration in World War II

Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor, Col. John Boyd Coates, Jr., MC, 613 pp., $6.25, U. S. Government Printing, 1963.

MEDICAL MILITARY history, very well done.

Medical Department, United States Army Preventive Medicine in World War II, Vol. VI Communicable Diseases—Malaria

Edited by Colonel John Boyd Coates, Jr., MC, USA, 642 pp., $6.25, U. S. Government Printing Office, 1963.

THIS VOLUME is on malaria.

Practical Malariology, 2d Ed.

By Paul F. Russell, M.D., M.P.H., Sc.D. (Hon.). Luther S. West, Ph.D., Reginald D. Manwell, A.M., Sc.D., and George Macdonald, C.M.G., M.D., F.R.C.P., 750 pp., Oxford University Press, 1963.

IT WON'T wear out soon in Hawaii!

★Physical Diagnosis, 2d Ed.

By John A. Prior, M.D., and Jack S. Silberstein, M.D., 455 pp., $8.50, The C. V. Mosby Company, 1963.

AN EXCELLENT, well-illustrated, handsomely printed volume. It would make a fine gift for a medical student.

★Strategies of Psychotherapy

By J. Haley, 204 pp., $7.75, Grune & Stratton, Inc., 1963.

PRACTICAL ADVICE in plain English, a most unpsychiatric way for the author of such a book to write. It turns out there is a reason for this: He is a Communications Analyst. He should live forever!

Health Care for the Community Selected Papers of Dr. John B. Grant

Edited by Conrad Seipp, 194 pp., $5.00, The Johns Hopkins Press.

FOR MEDICAL BUREAUCRATS, a fascinating volume. For others, either dull or like *Mein Kampf*, depending on your bias.

1st International Symposium on Stereoencephalotomy

Edited by E. A. Spiegel, M.D., and H. T. Wycis, M.D., 396 pp., S. Karger A. G., 1962.

FOR NEUROSURGEONS—and not all of them.

Fundamentals of Medical Education

By Thomas B. Turner, M.D., 80 pp., $3.75, Charles C. Thomas, 1963.

BASIC PRINCIPLES are thoughtfully discussed.

Review of Medical Physiology

By William F. Ganong, M.D., 577 pp., $6.50, Lange Medical Pub., 1963.

PHYSIOLOGY self-taught. Primarily a textbook. Plenty of diagrams.

Physiological Chemistry, 9th Ed.

By Harold A. Harper, Ph.D., 437 pp., $6.00, Lange Medical Foundation, 1963.

ALKYLATION IS NOT mentioned, but this ninth edition (since 1939) will clue you in on many changes since your intern days. The author is Professor of Biochemistry at Cal.

Human Sex and Sex Education

By Warren R. Johnson, Ed.D., 205 pp., $4.50, Lea & Febiger, 1963.

THE DEGREE of the author's objectivity toward socially inacceptable behavior verges on the appalling.

★Clinical Examinations in Neurology

By Members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota, 396 pp., $8.50, W. B. Saunders Company, 1963.

FIFTEEN MAYO neurologists and physiologists explain the neurological examination in detail, with diagrams. Curiously, the traditional and expressive word *festinating* (hastening) has completely vanished from the description of the Parkinsonian gait. It is called "the so-called propulsive gait."

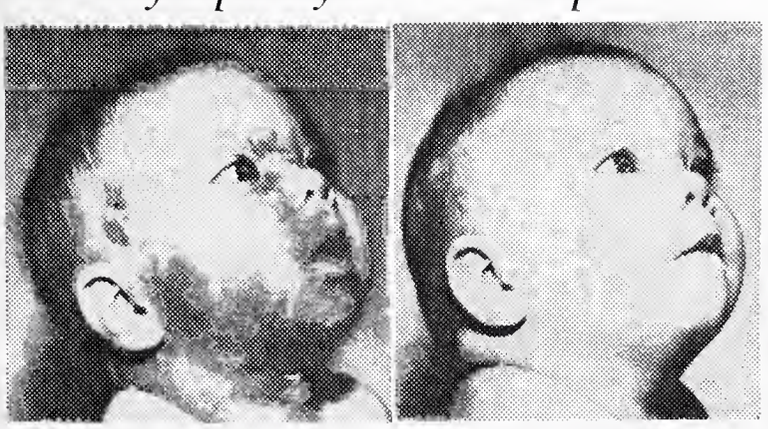
Early Cancer

By Leonard B. Goldman, M.D., 324 pp., $12.50, Grune & Stratton, Inc., 1963.

A BOOK ON early cancer should not encourage a physician to distinguish a benign gastric ulcer from a carcinoma by such unreliable signs as the presence of radiating folds. This one does. The chapter on skin cancer is full of curious statements such as "basal cell cancer almost never metastasizes" and "always confirm the diagnosis by biopsy." There is a strong bias toward radiation in treatment.

continued page 230

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Book Reviews *continued from 229*

Science and Psychoanalysis, Vol. VI Violence and War with Clinical Studies

Edited by Jules H. Masserman, M.D., 284 pp., $8.75, Grune & Stratton, 1963.

MILITARY PSYCHIATRISTS must have this. Others, happily, need not.

Handbook of the Practice of Anesthesia

By John R. S. Shields, M.D., Ch.B., F.F.A.R.C.S., 203 pp., $6.85, The C. V. Mosby Company, 1963.

FOR BEGINNING students of anesthesiology. Generously illustrated.

The Psychology of Meaningful Verbal Learning

By David P. Ausubel, 255 pp., $6.50, Grune & Stratton, Inc., 1963.

OF INTEREST largely to teachers, who might be better employed than in reading it. Very deep.

The Prevention of Hospitalization

By Milton Greenblatt, M.D., Robert F. Moore, M.D., Robert S. Albert, Ph.D., and Maida H. Solomon, B.A., B.S., 182 pp., $7.50, Grune & Stratton, 1963.

PSYCHIATRIC hospitalization is meant. *Verbum sapientibus!*

The Medical Treatment of Peptic Ulcer

By George Gordon McHardy, M.D., 78 pp., $4.75, Charles C. Thomas, 1963.

A STALWART rear-guard action by an embattled gastroenterologist of distinction, in the war over "peptic" ulcer versus gastric carcinoma. Strode, Lahey, Ravdin, and other surgeons are *not* quoted. As a treatment manual, however, it can be highly recommended.

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Notes and News *continued from 212*

George Chaplin in the *Advertiser,* and William Ewing of the *Star-Bulletin,* in full-page feature articles. Dr. H. Q. Pang was arrested by the Russians for snapping pictures of "bad things" (people and buildings), but was shortly released. The doctors also noted that nervous conditions at the Black Sea resort were treated with hydrogen sulphide baths.

Dr. Rodney T. West was quoted as saying that medical science has advanced more the last 25 years than it had in the previous 3,000 years, and that about 4.5 million Americans are alive today who would be dead, but for these advances.

Melvin Belli, the King of Torts, in a two-day seminar at the Hawaiian Village, said that doctors should consider suing lawyers for defamation of character, false suit, etc., if a malpractice charge against the physician is without much basis. And after this seminar, the doctors might expect more malpractice suits to be filed. Belli referred Hawaii attorneys to Brady's "Disease and Injury," Weiss's "Psychosomatic Medicine," Brock's "Injury to Brain and Spinal Cord," and AMA's booklet on medico-legal forms for legal analysis, so physicians might do well to reread these volumes.

Dr. Robert P. Jay has been named medical director of Ewa Plantation, following the retirement of **Dr. Garton Wall.**

Dr. Joseph Stokes III has left to accept the position of Dean of the new University of California Medical School at San Diego, to open in 1966 or 1967. Joe has done a superb job of organizing lectures and conferences at Queen's Hospital over the last two years and will be sorely missed. Good luck, Joe!

Dr. William F. Lyons, new Chief of Epidemiology at the Health Department, made the news when he announced that Oahu's fresh water swimming holes may harbor leptospirosis. An 18-year-old youth, it seems, contracted the disease after drinking water from Kapena Falls on the Nuuanu stream.

Dr. J. Kendall Wallis has been appointed Executive Officer of the Mental Health Division of the Health Department. He was previously on Maui.

Dr. Katherine J. Edgar reported that Hawaii's infant mortality is among the nation's lowest, at 21.7 per 1,000 live births. The range on the mainland is from 20.3 in Utah to 37.8 in Mississippi.

Dr. Elwyn C. Cook, a former consultant in religion and psychiatry for the Menninger Foundation, has been appointed clinical director of the Hawaii State Hospital.

After seeing New Guinea while attending a World Health Organization Meeting there, **Dr. Richard K. C. Lee** reported it as the "most primitive" place he has ever seen.

Government ℞

Nearly 150 persons from all of Hawaii's counties attended the two-day Governor's Conference on Rehabilitation of the Mentally Ill Adult, **Dr. Leo Bernstein,** chairman. **Dr. David Lee Pang** spoke on "The Physician and the Mentally Ill," and **Dr. William Cody** asked "Where Are We?"

Dr. Ira V. Hiscock, Professor Emeritus of Public Health, Yale University, gave the annual lecture in his name at the University of Hawaii's Orvis Auditorium in September. He has nursed Hawaii's public health program through the past 34 years, with periodic surveys beginning in 1929.

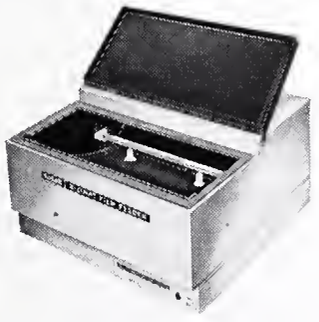
A three-year Federal grant, requested by the Hospital Association of Hawaii, has been given to the Health Facilities Planning Council, to seek methods of maximum use of Hawaii's present health facilities, without building new hospitals or unnecessarily duplicating services among the 34 hospitals in the State. **Dr. Edward Colby** (formerly of the Health Department) is the director. **Dr. Richard K. C. Lee** is President.

continued page 232



7 most important minutes . . .

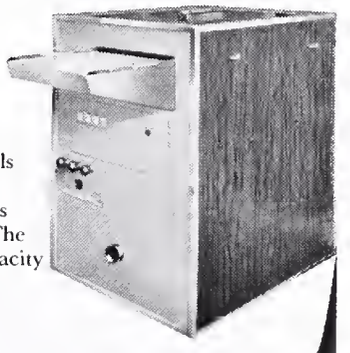
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Notes and News *continued from 230*

A new regulation forbids sale of poisons to anyone under 20. This is aimed mostly at "glue sniffing" products containing volatile organic solvents. The Food and Drug Branch of the Health Department has more information on this; call 507-711 Ext. 515.

The State's Social Service Department is asking a $9.6 million budget for 1964-65 fiscal year, nearly double its present appropriation. This will just maintain a "bare bone" welfare program, according to William G. Among, director.

Dr. Morton Berk was the keynote speaker at a luncheon meeting of the Governor's Committee on Employment of the Handicapped at the Princess Kaiulani on October 10. Governor Burns presented awards to firms which have hired the handicapped.

Miscellany

Richard Davi has been appointed administrator of Kapiolani Hospital to succeed the late **Pierson Dean.** Mr. Davi was formerly the assistant administrator at Queen's. He is also a part-time lecturer at the University of Hawaii in industrial relations.

Drs. George Mills, Bernard W. D. Fong, and **Joseph Stokes III** attended the American Heart Association Meeting in October at Los Angeles along with some 5,000 other doctors, nurses, and researchers.

Dr. Ralph B. Cloward made the circuit through Vienna, Tel-Aviv and back to Palm Springs, California, in September presenting his findings on cervical chordotomy.

Dr. I. L. Tilden was elected to the National Board of Directors of the American Cancer Society at their annual meeting in New York.

The locally hot issue of fluoridation has cooled temporarily, since the City Council in November squelched fluoridationist hopes in voting to postpone indefinitely any action on the measure, which means the issue cannot be raised again this session.

The new half-million dollar medical library has opened for business and **Dr. Grover H. Batten,** its President, is as proud as a father of quintuplets. The stately Ossipoff-designed structure stands just mauka of the Mabel Smyth Building on The Queen's Hospital grounds.

A new $150,000 wing to be completed this spring will add 32 beds in semi-private accommodations to the Leeward Hospital.

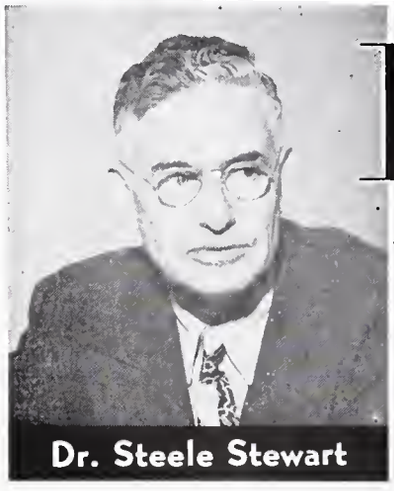
The East-West Center senior scholar program, under the direction of **Dr. Richard K. C. Lee,** is attracting both M.D.'s and Ph.D.'s from countries bordering the Pacific. They will work here on grants from six to 12 months, striving to solve problems in public health.

On the high cost of hospital care, **Will Henderson,** Queen's administrator, probably hit the nail when he said he believes there is a psychological shock attached to a hospital bill . . . the patient doesn't like the idea of paying for something he didn't want.'

The University has opened its Ossipoff-designed infirmary at the Diamond Head corner of the campus. **Dr. Earl D. Lovett,** Health Services Director, has stated he expects student visits to double in number as the facility becomes more operational.

The initial draft of a study for a proposed two-year Biomedical Science (and two-year Medical) School at the University has been completed by **Dr. Robert D. Tschirgi,** Academic Assistant to the President of the University of California. It is expected that the Univer-

continued page 234



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Notes and News *continued from 232*

sity's portion of the funding will be sought from the Legislature in February.

The American Society of Anesthesiologists have chosen **Dr. L. M. Tajima** as delegate and **Dr. Clifford K. W. Chock** as alternate delegate to their House of Delegates at the annual business and scientific meeting at the Palmer House in November, 1963.

The Queen's Hospital has been awarded a Clinical Fellowship for the study of cancer detection, said **Dr. Grover Batten,** President of the local Cancer Society.

A "beep" radio paging system has been installed at Mabel Smyth and is available to doctor members of the Physicians' Exchange for about $7.50 a month additional charge. The receiver is about the size of two packages of cigarettes (and is more healthful).

Local Contributions to Medical Literature

"Giant Blood Cyst of the Pulmonary Valve" by **Drs. Grover Liese, Scott Brainard,** and **Unoji Goto** in the *New England Journal of Medicine,* August 29, 1963.

"Cervical Discography" by **Dr. Ralph B. Cloward** in *Acta Radiologica,* May, 1963.

"Obstructive Cardiomyopathy" by **Drs. W. Harold Civin** and **Alvin Majoska** in the *Canadian Medical Association Journal,* September 7, 1963.

"Arteriosclerotic Abdominal Aortic Aneurysm" by **Dr. T. K. Lin,** *JAMA,* October 26, 1963.

"Echo Virus Type I and Aseptic Meningitis" by **Dr. Leon Rosen** *et al* in *Journal of Pediatrics,* September, 1963.

"The Community Impact of Handicaps of Prenatal or Natal Origin" by **Dr. Angie Connor** *et al* in *Public Health Reports,* October, 1963.

In the "Private Clinic Surgery in the United States" issue, October, 1963, of *Surgical Clinics of North America,* from the Straub Clinic: "Spigelian Hernia" and "Surgical Lesions of the Colon and Rectum in Hawaii," by **Dr. Joseph E. Strode;** "Management of the Thyroid Nodule," by **Dr. G. C. Freeman;** "A Practical Approach to the Treatment of Varicose Veins,' by **Dr. C. M. Burgess;** "The Quadrant Reflecting Incision in Surgical Procedures of the Upper Abdomen," by **Dr. James Cherry,** and "Inguinal Hernias in Infancy and Childhood," by **Dr. Niall Scully.**

Correspondence *continued from 168*

sport, and as such has little physical education value. The rest of paragraph 3 is worthy of Wolf Larsen.

Dr. Barnes' closing comment is interestingly predicated upon the magic words "not athletically oriented." How this apparently desirable and mystical state of "athletic orientation" guarantees infallibility of judgment about sports injuries is not explained.

Unfortunately, I do not have the New York State report available, but will certainly read it.

Finally, on rereading the letter as a whole, I have the impression Dr. Barnes has mistaken the basic assertions in my article about football injuries to mean I criticize all contact sports, which is not so. Other group sports such as soccer, basketball, baseball, doubles tennis—all these provide outlets for cooperative competition for everyone interested.

A clipping, containing figures presented to a meeting of

continued page 236

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Esters	0.03%	0.01-0.13%
Aldehydes	trace	trace-0.03%
Formaldehyde	absent	absent
Furfural	absent	trace-0.01%
Alkaloids	absent	absent
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Correspondence *continued from 234*

the American College of Sports Medicine, was included with his letter. The figures deal with high school football injuries. Admittedly, it is risky to discuss data from a news clipping, but since he sent it as evidence, I will accept it as such.

In the opening argument, he describes in one season 128 injuries among 520 players in Austin, Texas, of which 28 injuries were fractures. In Senior High play in Austin there were 226 injuries among 480 players, with 27 fractures.

The remainder of the article gives rundowns on several other North Carolina cities, with Junior H.S. football programs. Injury frequency reports were obtained from various "sports oriented" persons, largely recreation and athletic directors. All the reported rates are improbably low, when compared with Dr. Barnes' own rates from Austin. Without a detailed account of the method Dr. Barnes used for gathering the figures he presents in his clipping, one cannot accept them at face value. For example, he cites the record of Smithfield, N. C., where in three seasons of football "we have not had a fracture or an injury needing hospitalization (in) four teams composed of 25 to 30 boys each."

In Kingston, N.C., with 400 players, Dr. Barnes reports "only one fractured wrist spoiled a non-injury year" (!) Figures like these are either miracles of play or more likely, miracles of reportage, for which I am sure Dr. Barnes was not responsible.

In the Austin figures cited by Dr. Barnes, this is roughly one player injured in four, of which one in four injuries was a fracture. In the second Austin example, one player in two was injured—one in eight injuries was a fracture.

Battle casualties in World War II ran about 1 to 8, so it would appear that even by Dr. Barnes' figures, football in Austin, Texas, is a very dangerous game.

Considering the wide disparity in football injury figures from even a single source such as Dr. Barnes' clipping, and the emotional overlay inherent both in football and the considerable professional and economic machinery that keeps it going, it is doubtful that anyone, except its critics, can ever realistically assess this anachronistic activity.

Living in today's world requires individuality, early development of a strong sense of personal identity, and a basic knowledge of skills useful in any emergency. Few of these result from the customary P.E. programs in our schools. Emphasis has been on adjustment, games, and the development of a faceless anonymity in team activities that reflects itself in our physically derelict adult population.

Games are no longer enough. The institution, at the high school level, of a P.E. training program incorporating skills borrowed from the services should be considered—some of the time presently spent in game play should be replaced by formal training in survival techniques, Judo instruction, swimming and diving experience, and gun handling. These skills would better prepare our people against losing themselves in the woods, personal attack, drowning accidents, shooting off toes, and the numerous other mishaps that daily remind us of the lack of reality in our planning for adult physical activities, or even simple preservation of life in an emergency. If an assailant jumps from the bushes in the local park, how to throw a forward pass is not particularly useful information. I am sure Dr. Barnes will agree it is time we revise our physical education concepts to fit our population needs. Football may go or stay—it makes no difference as long as the total package of "p.e." training remains useful throughout life.

FRANK L. TABRAH, M.D.

December 10, 1963



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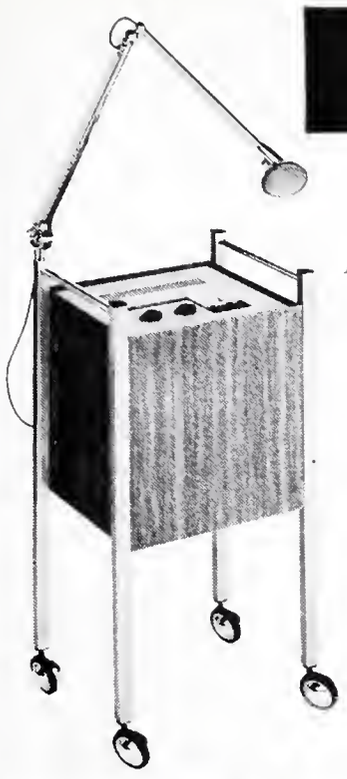
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County Society News *continued from 210*

troduced to the Society: Drs. Donald H. Ikeda, Edward L. S. Jim, Toshihiko Kawasugi, James A. Nishi, Betty S. M. Soo, Lawrence H. Winter.

The President announced that 34 volunteers were recruited to serve on a panel to review medical examinations of visa applicants traveling to the Philippines. The problem of legislative action to control the practice of medicine by unlicensed physicians was referred to the Legislative Committee. The Board of Governors requested that all members who are asked to serve on committees or participate in community activities advise the Society of these requests.

Following a talk on "Clinical and Laboratory Approach to the Infected Patient" by Dr. Lowell A. Rantz, the President reviewed the past actions relating to the appointment of an assistant medical director at the HMSA. In view of the information outlined it was recommended that this matter be referred back to the Board of Governors for final action. There were no objections or recommendations from the membership.

Dr. Frissell reported on the activities of the Inter-Professional Relations Committee, and Dr. Lum reported on the negotiations with HMSA being carried on by the HMA. Dr. Richardson reported that the reason Medicare claims had not been processed was because the HMA had delayed signing the contract.

* * *

Approximately 160 members attended the November 5 meeting. The following new members were welcomed into the Society: Drs. Thomas C. Brown, Jr., Donald F. B. Char, Rainie Grant Howard, Earl Dean Lovett, Alexander Roth, Dudley S. J. Seto, James B. H. Young, Bernice R. Walters, and Francis T. Oda.

The Nominating Committee's slate was presented. No additional nominations were made from the floor. Dr. Reppun questioned the Society's stand favoring fluoridation. He was advised that in 1959 the HMA's House of Delegates voted in favor of fluoridation and there has been no change in the stand since that time. Dr. Tomita advised that the HMSA, with the approval of all four county societies, changed its Participating Physicians' Agreement to permit the HMSA to refer the records of improper billings to the medical societies for review. He urged the doctors to sign the modification.

Kauai

The November 5 meeting was held at the G. N. Wilcox Hospital. Guests present were Drs. G. Evora, George Ewing, W. G. Herter, and J. Battista. The Society discussed the problem of visas to the Philippines. It was decided to recommend that people who are desirous of obtaining a visa should contact their own physicians.

A letter was read from Mr. J. R. Veltmann of HMSA which advised that the appointment of the assistant medical director had been unanimously disapproved by the Honolulu Board of Governors and that before action could be taken it was necessary for this matter to be reviewed by their Personnel and Executive Committees. It was voted to write the President and the Board of Governors of the Honolulu County Medical Society and ask their reasons for taking this action, and to reaffirm the recommendation of the Kauai County Medical Society that Dr. Nishigaya be appointed Assistant Medical Director of HMSA.

The Nominating Committee submitted its report for the county slate and recommended that the new president name the delegate to the HMA and make the other committee appointments.

Drs. Fujii, Kim, and Brennecke were appointed to a committee to work with the hospitals in an effort to recruit a permanent pathologist and radiologist on Kauai.

In response to a letter from the Department of Health, it was voted to approve and support the establishment of a Convulsive Disorder Clinic. The meeting concluded with a talk by Dr. George Ewing on convulsive disorders in children.

HMA President Rodney T. West and President-elect Samuel D. Allison were present at the annual meeting held on December 2. The following officers were elected: President, Kenneth K. Fujii; Vice President, Webster Boyden; Secretary-Treasurer, Yonemichi Miyashiro.

It was voted to have a joint meeting with the nurses and invite Drs. Virginia Apgar and Donald Char. Dr. Peter Kim was appointed to represent the Society in setting up a Convulsive Therapy Clinic on Kauai. In answer to a request from HMSA to submit a list of nominees from which they could appoint a replacement for Dr. S. R. Wallis whose term on the Review Committee expires on December 31, 1963, the name of William W. Goodhue was agreed upon. It was voted to refer to the new president the review of the Heart Association's proposed programs.

Dr. Kim circulated to the members the suggested criteria by the ADA for interpretation of glucose tolerance tests. Dr. Boyden was appointed to conduct the high schools and work with their counselors for career week.

The rest of the meeting was devoted to the reports of Drs. West and Allison.

Maui

Dr. Andrew C. Ivy, Jr., discussed the HMA public relations program at the October 15 meeting. Dr. René Joyeuse was elected into the Society. Correspondence from the Workmen's Compensation Bureau was discussed. The names of Drs. Wong, Tompkins, and Underwood were submitted for appointments to the Mental Health Committee. A project involving a simulated bus-truck collision at Baldwin High School will take place during Community Health Week. A Nominating Committee was appointed by the President. There will be no November meeting and the Christmas Party will be dispensed with in favor of a December meeting at Kaanapali.

Hawaii Medical Association *continued from 206*

facts and statistics have been gathered on the basis of a two- and four-year medical school, the doctors should take a stand one way or another. The Medical Education Committee should be urged to develop facts and move quickly. Members of the Honolulu County Medical Society should be kept informed of developments.

Mental Health: It was pointed out that government and lay groups should not control impetus for mental health planning. If doctors do not participate to a greater degree, control will fall in the hands of nonphysicians. Nonpsychiatrists should take a greater interest and not leave this in the hands of a small group of psychiatrists.

Message of the Month: The following messages have been sent out: June, School Physical; August, Sunburn; September, Smoking; October, Immunizations; November, Diabetes. The December message will be respiratory disease; January, Obesity; February, Heart. Subsidies from outside sources have been received, or promised, for the following: Smoking (Cancer Society), Diabetes (Eli Lilly), Respirtory (TB Association), Heart Disease (Heart Association). These subsidies, plus the selection of a new printer with a much lower printing cost, is keeping the committee's expenditures well below the amount budgeted.

Nurses Liaison: There was a meeting regarding recruitment of nursing candidates and a notice on this appeared in the Newsletter. County society presidents were advised of the critical condition that is expected if more nurses are not trained.

Public Relations: No report.

TV-Radio: The TV program has a new time—one hour every Sunday beginning at 9:00 p.m.

News-Media: This subcommittee is in the process of entertaining members of the press at a series of luncheons. It proposes to offer to help the press by suggesting subjects for the press to be worked into news articles. It

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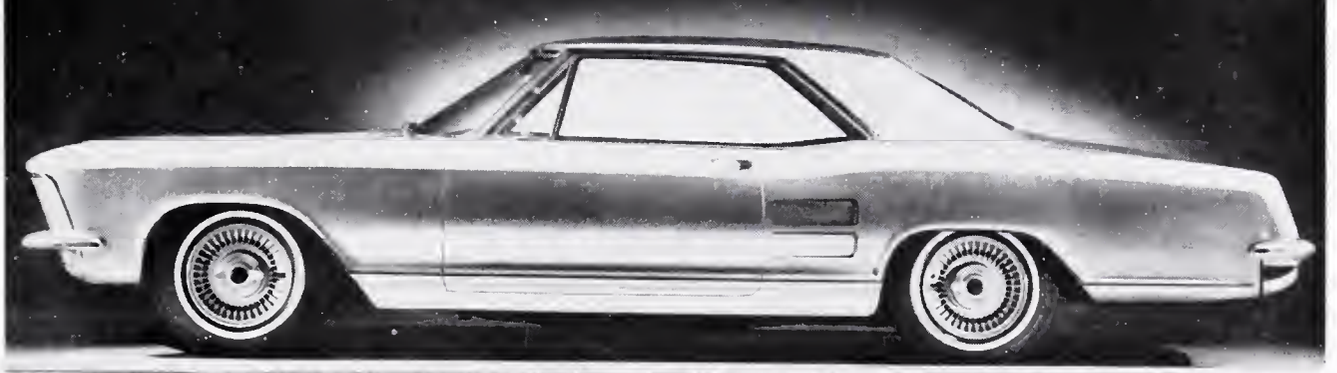


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Hawaii Medical Association *continued from 238*

also proposes to work with the hospitals in developing policies relative to releasing informaiton on patients.

Radiation Committee: No meetings yet. The Committee proposes to institute radiation safety inspection of all machines in the State.

School Health: The Committee has completed work on 7th grade physical examination for 1963-64, physical examinations for school sports programs, and review of health hazards in school cafeteria work. Dr. Bernstein was advised that the Committee felt the health hazards are minimal and can be kept under control by proper supervision. Continuing activities include tuberculin testing in school as part of routine physical examination. Proposed activity is prenatal care for teenagers in schools.

Tuberculosis: The Committee advised the Department of Health it approved the proposed amendment which would exempt persons under 20 from having a chest x-rays in order to work as food handlers.

ACTION:
It was voted to stand baek of this committee's aetion.

NEW BUSINESS

Nursing Home Survey: The proposed survey forms were approved in principle by the Chronic Illness & Aging Committee and referred to the Council.

ACTION:
It was voted to refer this baek to the Chronie Illness & Aging Committee for more information relative to the purpose of this survey.

Publication of Minutes in the Journal: There was a discussion of the advisability of making minutes public. It was noted that reporters make statements from these minutes, which is poor public relations.

ACTION:
It was voted to gather more information relative to policies followed by other societies and report baek to the Counеil.

Eli Lilly: Eli Lilly has again proposed to offer the Association money instead of exhibiting at the annual meeting.

ACTION:
It was voted to deeline Eli Lilly's offer of a donation.

Role of Council for 1964-65: Definitive action was deferred.

Photographs of Doctors: An offer from a photographer to take pictures of the doctors was reviewed. It was noted that Mr. Bauer has asked to be relieved of this responsibility.

ACTION:
It was voted to aecept Mr. Bob Johnson's offer, and to investigate the possibility of printing a roster.

Association Reorganization

The proposed reorganization chart was submitted to the Council and discussed in detail.

ACTION:
It was voted to approve the chart of reorganization of the Exeeutive Offiees as eireulated and to authorize the Exeeutive Seeretary to employ Mr. William Dodge as an Administrative Assistant on a one-year eontraet.

Committee Responsibility and Authority: It was felt that committee action, in general, should be approved by the House of Delegates or, in interim, by the Council except under unusual circumstances. Any committee action may be approved by the President upon his own authority or following consultation.

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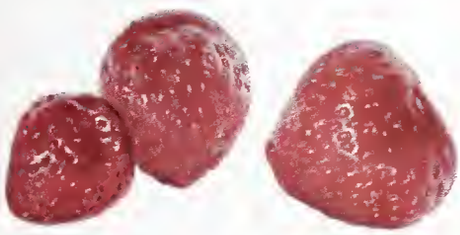
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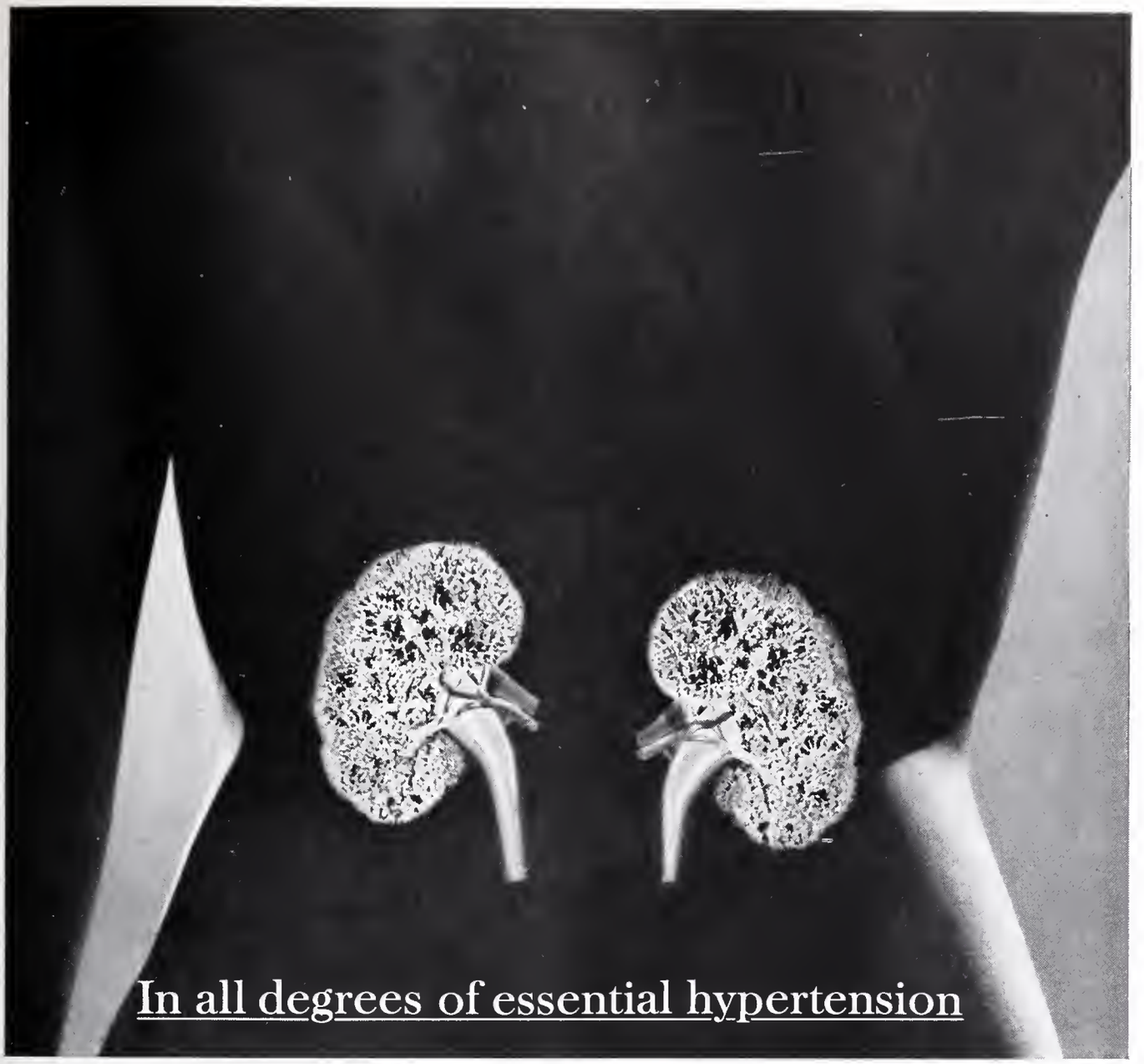
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VOLUME 23, NUMBER 4 • MARCH-APRIL, 1964 • $6.00 A YEAR, $1.00 A COPY

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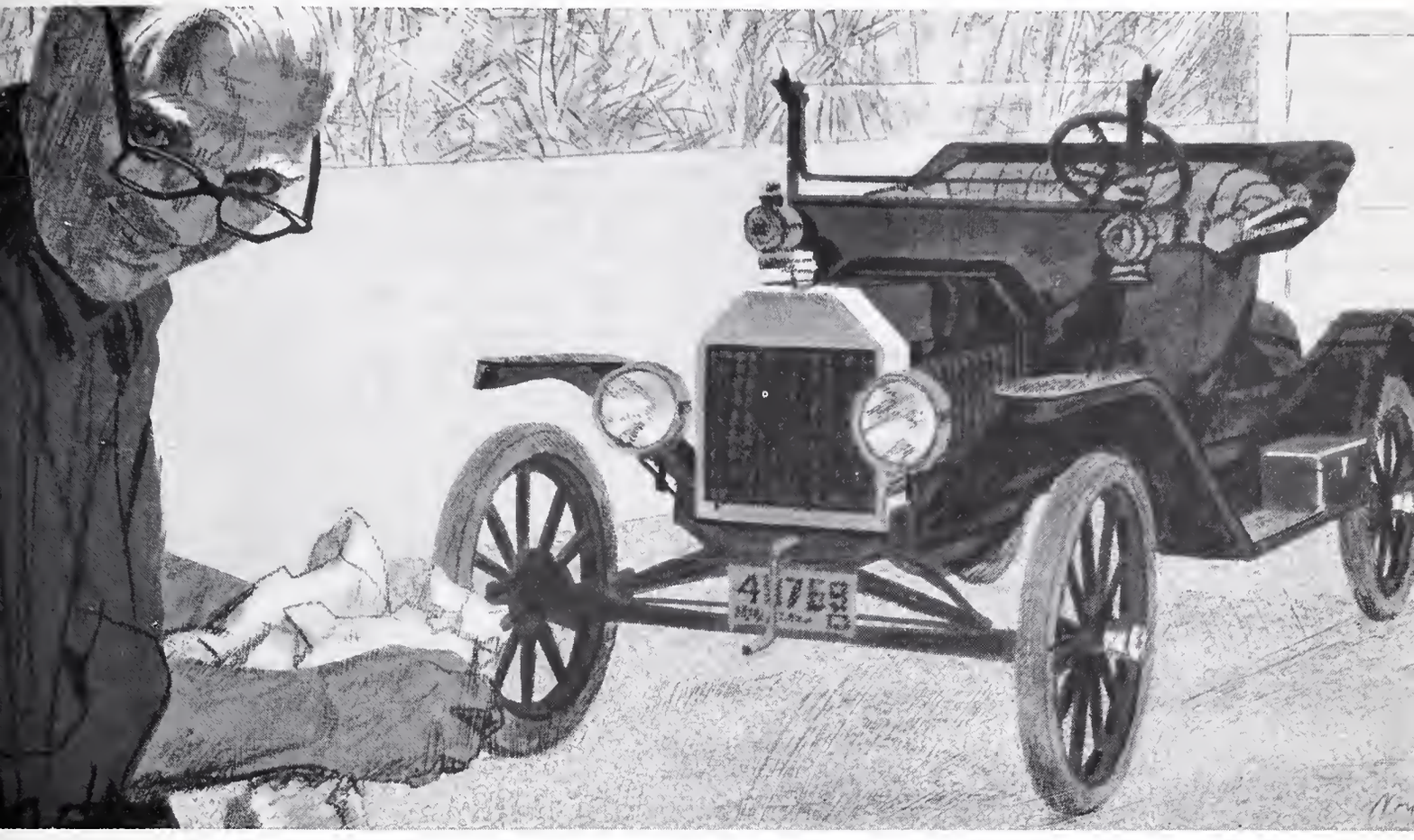
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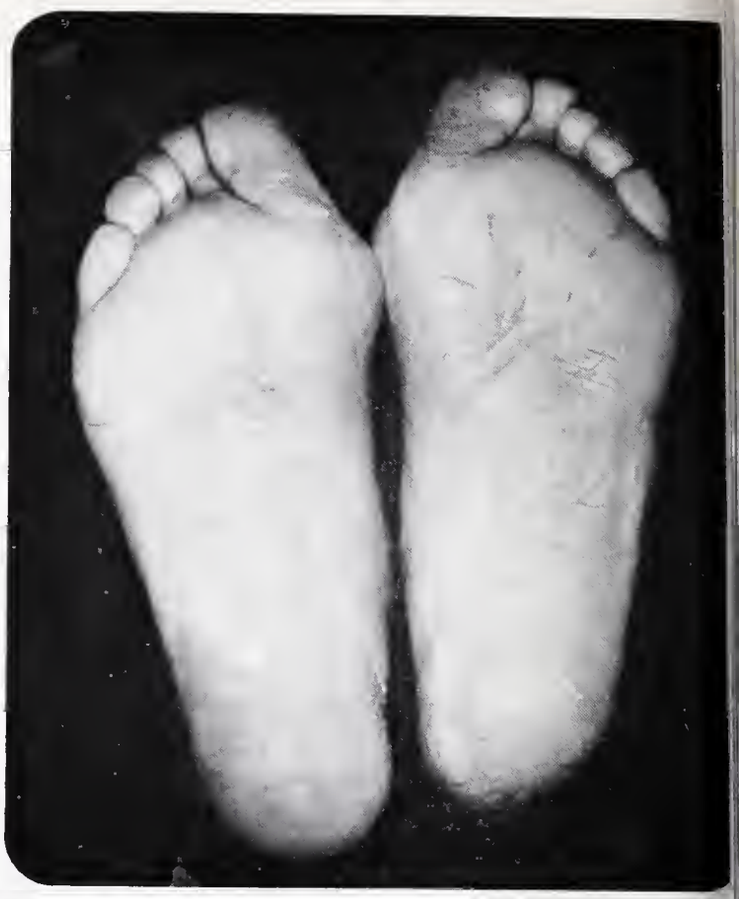
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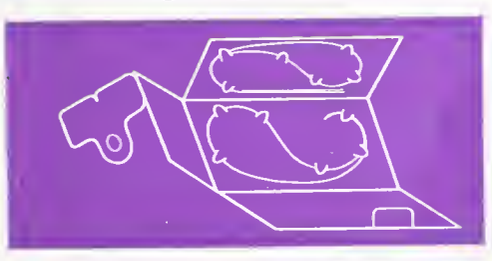
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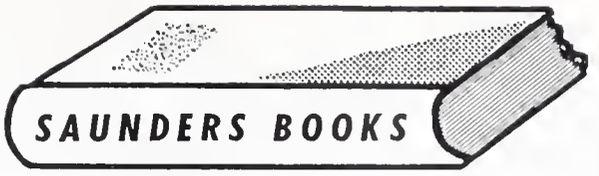
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Reports & Snorts

Salpinx, like *tuba,* meant and means "trumpet," not just plain "tube." *Syrinx* and *tubus* were the Greek and Latin words, respectively, for "tube," though they were sometimes used to designate a musical instrument, according to Alexander Gode in a recent issue of *JAMA.* The neural tube was named from *tubus,* a simple tube; the eustachian and fallopian tubes from *tuba,* a trumpet—hence, *salpingitis* when they're inflamed, diseases being named from Greek as anatomical terms are from Latin.

• • •

Dr. Esmond R. Long, Emeritus Professor of Pathology at the University of Pennsylvania's Henry Phipps Institute, became Editor of the *International Journal of Leprosy* January 1, 1964. He succeeds H. Windsor "Prexy" Wade, Editor of this journal since its foundation in 1933. Dr. Wade remains Editor Emeritus and will continue to participate in some phases of the editorial job.

• • •

The Captain of the firing squad stepped up and offered the condemned man a last cigarette. "Are you out of your mind?" screamed the victim. "Haven't you read the Surgeon General's Report?"

• • •

If you see cigarette vending machines without a SALES OF CIGARETTES TO MINORS ARE FORBIDDEN sticker affixed to it, do your part by asking the proprietor to see that one is obtained and posted. This is part of the official policy of the National Automatic Merchandising Association.

• • •

Ayerst's Ophthalgan is a newly marketed pure anhydrous glycerine preparation for eye instillation to reduce corneal edema.

• • •

Been told to go fly a kite? Send a dollar to Alan-Whitney Co., 165 Dwight Street, New Haven, Connecticut 06502, and get a beautiful bird-shaped tailless kite with a 45 inch wingspread.

• • •

Write to Johnson and Johnson for offer S-5386: a handsome plastic office dispenser for five sizes of Band-Aids, for free.

• • •

Had you heard about the Jewish Mafia? It's the Kosher Nostra, of course.

• • •

Know what a painful callus on a policeman's toe is called? Corn on the cop.

National Instrument Company in Baltimore announces production of a direct-reading serum protein and urine specific gravity meter. After adjusting to zero with a drop of distilled water, you put a drop of serum (or urine) on the prism and read off the protein content (or specific gravity, as the case may be), from 0 to 12 grams per 100 ml in 0.1-gram units, or from 1.000 to 1.040 in increments of 0.001.

• • •

Computer Instruments in Hempstead, L.I., announces production of a direct-writing electromechanical recorder for Achilles tendon reflex timing. A pedal against the foot transmits its motion to the writing stylus, electrically.

• • •

You may have thought you knew what "SOB" means. It means "See Order Blank" or "Shortness of Breath" or "SubOccipitoBregmatic," according to the *Medical Abbreviations Dictionary,* available from the Michigan Occupational Therapy Association, University Hospital, Ann Arbor, Michigan for $2.25. "SLB," mysteriously, means "sedative cabinet bath." "SONP" means "soft organs non-palpable."

• • •

A Mathematical Query

And what mean all these mysteries to me,
Whose life is full of indices, and surds?
$x^2 + 2xy + 23$
$= 11/3.$

—Lewis Carroll

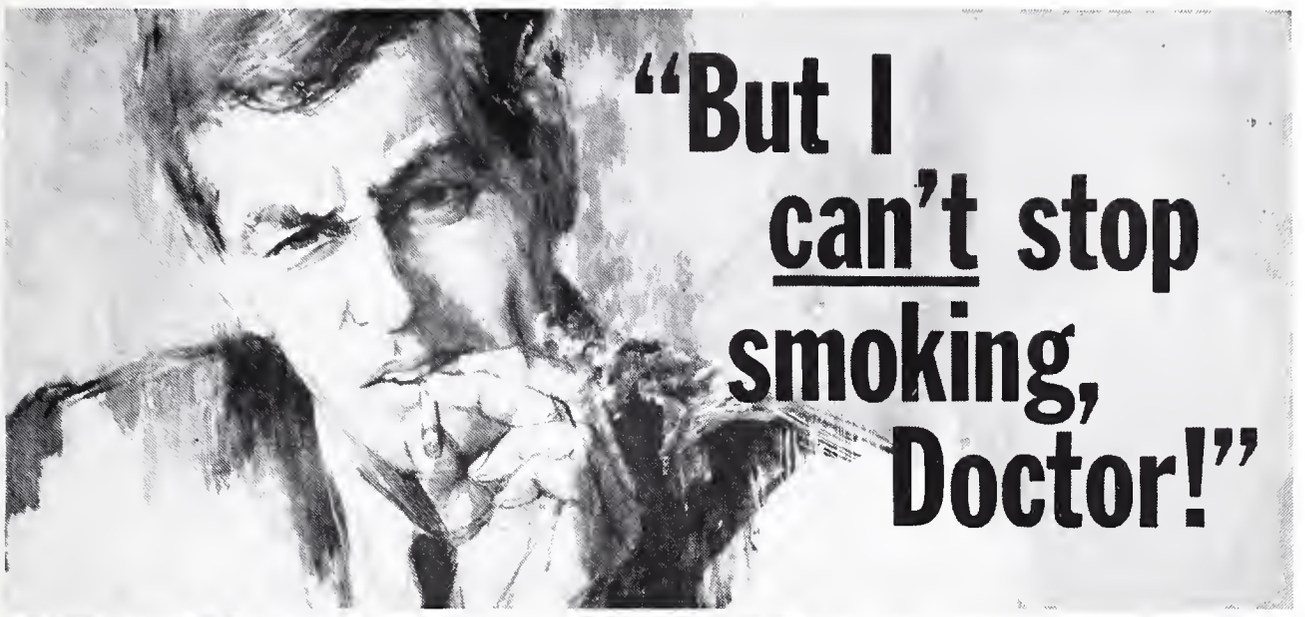
• • •

Uncle Sam is watching over us all the time. *Congestive Heart Failure: A Guide for the Patient* is the title of a 10-cent brochure prepared by the United States Public Health Service. Also available at the same low price (10¢ each or $5 per 100) is *Understanding the Management of Congestive Heart Failure.* Write the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Or for a single free copy of each, write the U.S.P.H.S. direct.

• • •

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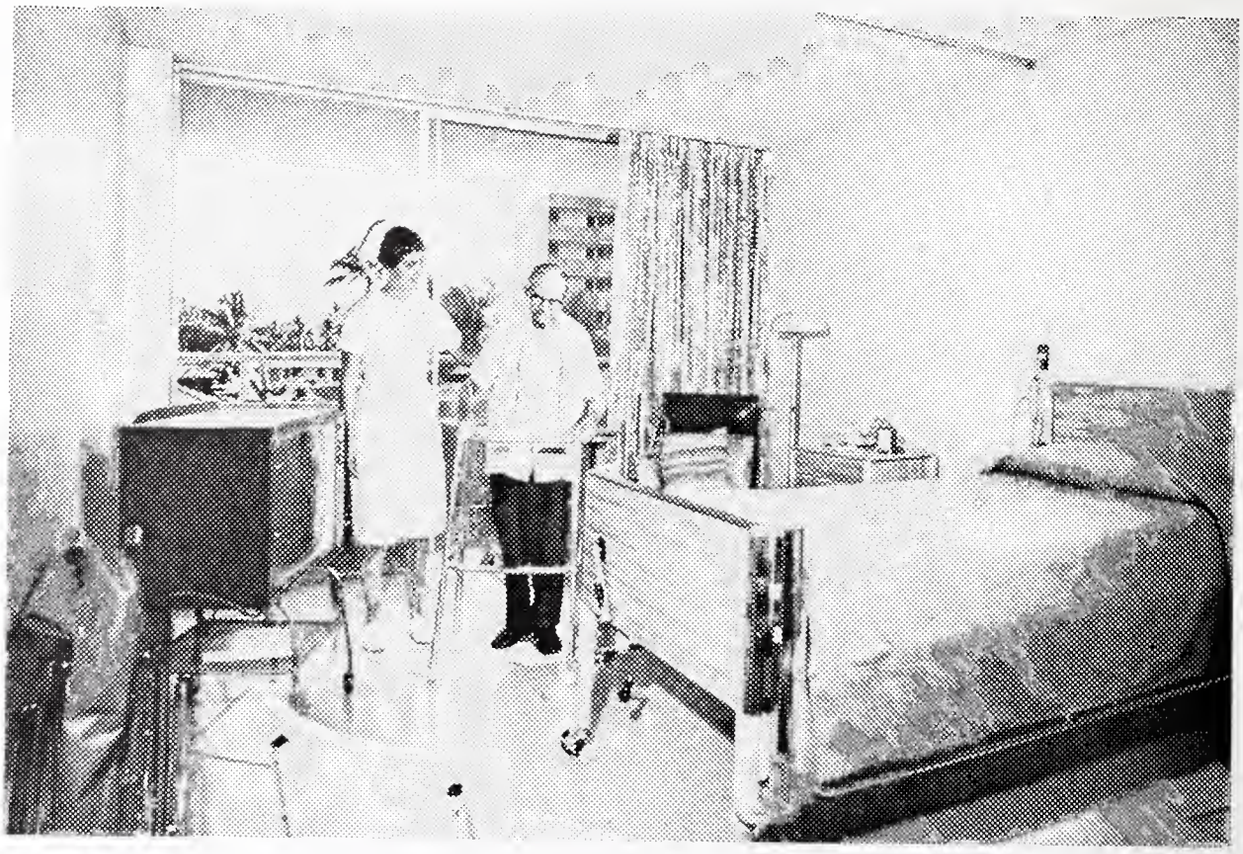
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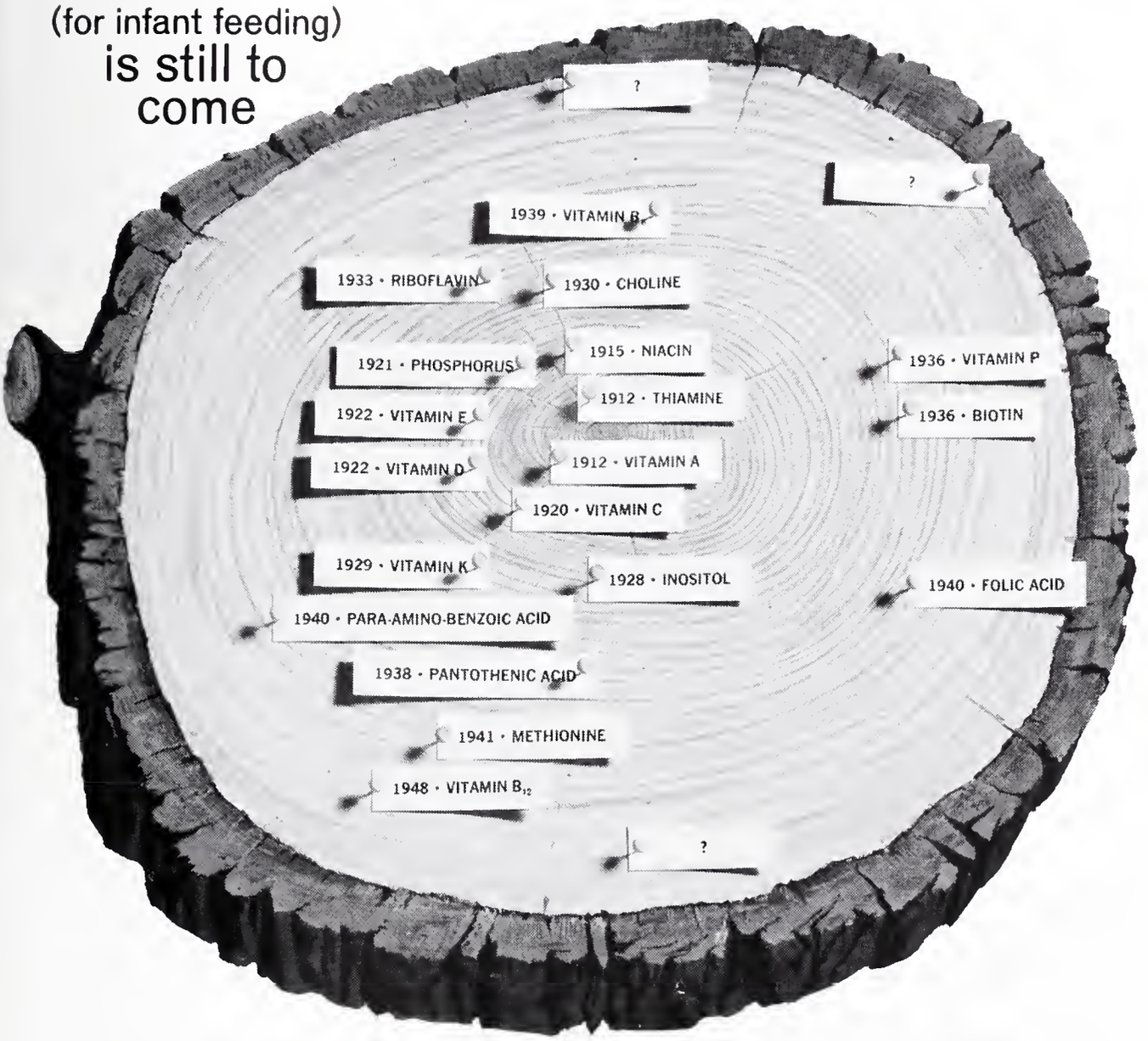
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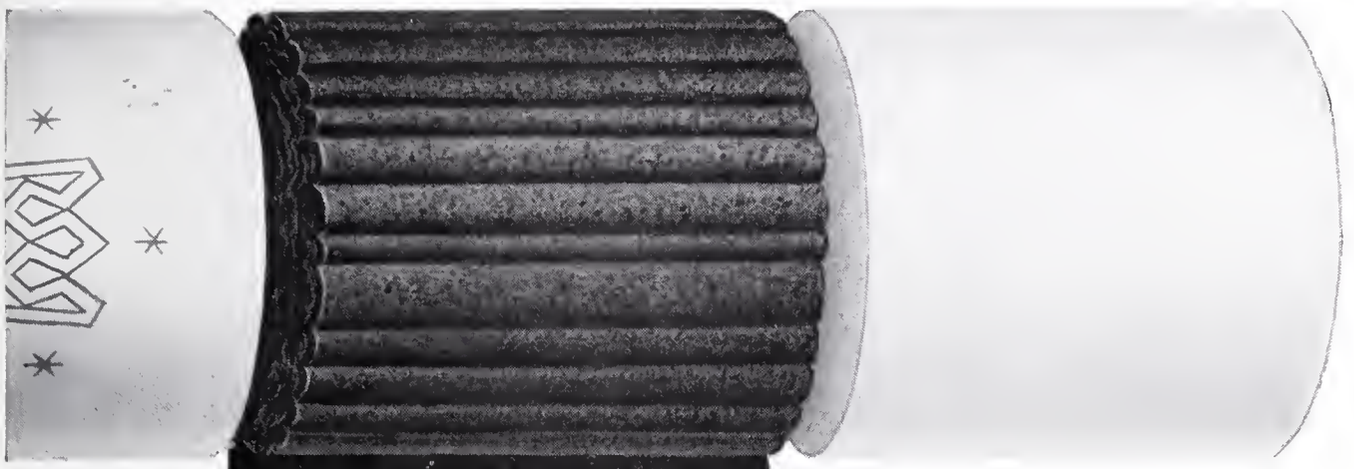
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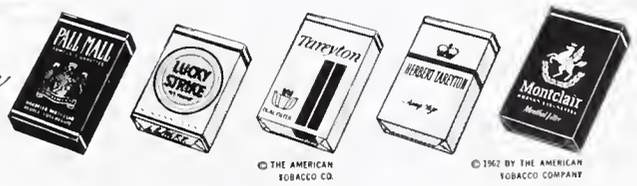
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Viruses may be the cause of some cancers. Possible modes of transmission are viewed in this thoughtful address.

Viruses and Cancer — A Review

JAMES P. COONEY, M.D.,* *New York*

• *Lysogeny (participation of a virus in the hereditary mechanism of a cell), transduction (transfer of hereditary material from one cell to another), and vertical transmission (passage of an infective agent to the next generation instead of to a member of the host's own generation) are three mechanisms which may help to explain how viruses can cause cancer. Modern techniques of identification and blocking of viruses suggest that new methods of diagnosis and control may become available soon.*

VIROLOGY is not an old science. The term virus was coined only 65 years ago when a fatal rabbit disease, myxomatosis, was found to be due to an ultramicroscopic agent.[30] At the same time a foot-and-mouth disease in cloven-footed animals was similarly attributed to an agent which could not be seen under the microscope. Only the recent advent of the electron microscope made it possible to visualize the smallest pathogenic agents, the virus.

What is a virus? Stanley[35] defines it as "something infectious and extremely small which has the ability to cause disease in almost all living things and which can reproduce only within living cells." Some viruses have been described as remaining lifeless as a rock for years at a time; electron photomicrographs of crystalized virus, such as the tobacco mosaic or poliomyelitis viruses, have dramatically demonstrated this.[35] Viruses may come to life at any minute, so to speak, if and when a vulnerable cell becomes part of the environment.

Viruses have been blamed for more than half of the infectious illnesses plaguing man today, and for hundreds of plant diseases and innumerable diseases in animals. Even the smallest organisms are not immune. Bacteria are not infrequently infected, the phage of E. coli being an excellent and familiar example of a bacterial virus.

During recent years a great many new viruses infecting man have been discovered.[24, 29] It has been estimated that as many as 200 viruses previously unknown in humans have been demonstrated since 1955. Many of the new viruses have been found following development of the electron

Read before the Hawaii Medical Association Annual Meeting, May 3, 1963.

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microscope. As reviewed by Dmochowski,[13] electron microscopy of viruses in tumor eells was attempted soon after the initial studies of other viruses.

The physical appearance of virus particles varies eonsiderably. Thc virus molecule may take many forms, spherical, elongated, or with or without a tail. They are uniform in one respect, however. Thcy arc composed of nucleie acids with a protein eoating forming a sheath around the virus eore.[3]

Bacteriophages are eomposed of deoxyribonucleic aeid (DNA) while plant viruses appear to havc only ribonucleie acid (RNA).[31] The animal viruses, including those whieh inhabit man, are more sophistieated.[33] They may contain either DNA or RNA or both, and some are also known to eontain lipids, enzymes, and carbohydrates.[9]

There seems to be no definitive information as to how viruses originated. Far baek in time they may have developed when life was first begun on earth, or they may be a kind of degenerate microbe whieh has decided to no longer shift for itself but to adopt a parasitic role and live off the efforts of others. Or it may be that these pseudo-organisms werc originally cell particles whieh have acquired autonomy to a degree.[26]

At any rate we are certain that viruses, if not aetually living organisms, fulfill most of the criteria for this definition.

VIRUS EFFECTS

Thesc minute but eomplex molccules may remain dormant for long periods of time, resistant to extreme ranges of temperature. As Stanley in his historie work first demonstrated with the tobaceo mosaie virus, they may be erystallized and later resume their life eyeles in the proper host environment.[8]

Viruses are specifie pathogenie agents and can eause symptoms of charaeteristie diseases. Some viruses may inhabit the plant and animal kingdom harmlessly while others are well known for their damaging effeets. Some of these agents have a wide host range, seeming to be at home in a number of species, while others inhabit and reproduee in only a single kind of plant or animal. Many viruses can be transmitted directly from host to host, but others need a morc complieated route. Insect vectors as intermediary hosts are not uneommon.[15]

For viruses whieh inhabit a single speeies, some have a preferenee for eertain organs or tissues in which to replicate and multiply. Among those which cause disease symptoms, some viruses apparently ereate their effects only oeeasionally, or when stimulated to do so by special conditions. An example of this type is herpes simplex virus,[26] whieh usually infects humans at an early age and remains latent throughout a lifetime, only oecasionally if at all demonstrating its presence. One theory suggests it may be aetivated during periods of fatigue or emotional stress and henee might be ealled an emotionally sensitive virus.

VIRAL REPRODUCTION

Various authorities have agreed that a virus may be deseribed as a submicroscopic obligate intraeellular parasite.[20, 33] A charaeteristie of viruses is their ability to disappear or lose their identity upon entering a cell.[38] After the cell becomes infeeted, the virus may not immediately replieate but instead it is believed that the viral DNA may beeome incorporated into the genetic material of the eell. As the eell reproduces, the virus material, indistinguishable from the cellular nucleic acid, is eontinued or maintained for suecessive generations.

Reproduetion of ordinary microscopic organisms, by binary fission in geometrical progression, is in sharp eontrast to viral replieation.

Viral reproduction begins when the virus molecule attaches itself to the outside of the cell, the eytoplasmie membrane. A chemical reaction takes place between the protein shell of the virus and the membrane. Upon penetration, the virus empties its nueleie aeid into its new host.

A virus-infeeted cell, after a lateney period whieh varies for different viruses, may produee as many as 200 or more virus particles. Immediately after infeetion no traee of the virus can be found by either electron microscopy or bio-assay. Later, virus particles do appear in the nucleus or cytoplasm, either in groups or seattered throughout the eell.[20]

Viruses are released from their captive cells in several ways:[33] by transfer to new cells through the regular process of eell division, the virus riding along like a passenger; or through discharge of virus partieles through cytolysis, the host cell being destroyed; or simply by diseharge of virus particles into the circulating systems, the host eell remaining alive—but perhaps changed.

VIRAL TRANSMISSION

Vertieal transmission has been postulated as the method by whieh oneogenic viruses may be transmitted. This phenomenon, long recognized in transmission of Rickettsia through successive generations of their arthropod host, is now being vigorously studied for some of the animal cancer viruses.

The evidence for viral causation of cancers in various species of animals spans more than 50 years. The list of malignant tumors caused by clearly identified viruses is growing rapidly. Most

of the malignant tumors in chickens and mice, and perhaps in rats and frogs, have a viral origin. And it is conceivable, according to Stanley, Gross, and many other authorities, that virus-induced tumors in chickens, mice, and other species are not essentially different from those seen in humans.

CANCER VIRUSES

Many questions remain to be answered, however: such as whether all malignant tumors are caused by viruses; whether viruses are a necessary adjunct to all carcinogenesis or represent only one of many factors, each capable of inducing cancer.[23]

Another question is whether viruses may be necessary only for the initial stage of cancer and not for continued growth.[7] Many authorities are now exploring this possibility. Recently, I heard Dr. Lev Alexandrovich Zilber of Moscow expound some of his theories thus:

"Many animal tumors are caused by viruses, and it is now possible to describe, in part at least, the viruses' action on the organism. This action takes place in two very distinct phases.

"First, normal cells are genetically transformed into cancerous ones, a transformation which has no clinical manifestation. Second, these new tumor cells reproduce, leading to the *clinical entity* of cancer. It is important to understand that in this second phase, the virus plays no *important* part, if any at all. Much evidence has accumulated to support this view and to indicate that, after the infectious phase, the virus may disappear from the cancer.

"In Rous sarcoma, experimentally induced by virus infection, the virus can no longer be found in the tumor 40 days after inoculation."

Dr. Zilber showed that in his laboratory the titer of polyoma virus in a culture of hamster tissue gradually starts to decrease after the second week following inoculation. By the end of the fourth week, virus can no longer be found by any known method. In some tumors the virus may occasionally remain, but it is likely to be a passenger virus, no longer necessary for the development or growth of the cancer it has triggered.

The usual concept of infection has inhibited investigators from considering cancer as "contagious." In humans, of course, there is no possibility that cancer is "catching" as the common expression would have it. Under experimental conditions, laboratory animals with viral cancers can be kept near healthy members of the same species without infecting them. However, there have been occasions, such as with the polyoma virus, on which a cancer virus in a laboratory has unexpectedly infected other animals into which it has not been deliberately introduced.[1]

Nevertheless, it is generally accepted that viruses such as those causing leukemia in mice or chickens, or mammary cancer in mice, are transmissible; but, this is accomplished over many successive generations. As an example, Gross[17, 21] has shown that spontaneous leukemia in strain AK or C58 mice is transmitted from one generation to another. Although the offspring have been infected since birth or even during the fetal period, (the virus being recoverable from the fetus) leukemia does not appear until many months have passed. Or it may not appear at all, but symptom-free mice still pass on to their progeny the leukemia agent. It is probable that the virus is transmitted in an inactive state through the germinal cells, to become active at a later stage in the life cycle.

Other examples of this type of viral transmission are seen in chicken lymphomatosis, shown to be transmitted through the embryo,[2] and the Bittner milk factor, transmitted through the milk of nursing mothers.[6] In these cases, appearance of neoplastic growth does not always occur. Obviously, viral infection is not always followed by occurrence of a tumor. It may also be said that tumor viruses are certainly prevalent in animals, and it seems certain that not every host bearing such factors will develop cancer. We must assume that in such instances they are merely carriers of neoplastic disease.

The polyoma virus, which has shown to be capable of leaping the species barrier,[14] certainly remains harmless from a standpoint of active disease for most of its murine hosts. Spontaneous cancer is a rare occurrence in mice bearing the polyoma virus, but this factor regularly and in a high percentage of cases induces a variety of tumors when injected into newborn animals. It also can be activated in older animals, or the hosts themselves, by various means, including irradiation or steroid hormones.

VERTICAL TRANSMISSION

We normally think of contagious diseases as being transmitted from host to host in the same generation. The methods of contagion in most viral communicable diseases have been identified. The Gross leukemia virus and probably other cancer viruses are communicated through vertical transmission. This transmission of the cancer agent through succeeding generations can be compared with transfer of the Rickettsia of Rocky Mountain spotted fever. This agent is transmitted to man through the tick, but is carried through the egg of this insect from generation to generation without apparent harm to the host.[11, 25, 27] Yet this pathogen and others, such as the tularemia organism, cause disease in man while failing to affect

their own carriers. Only in other species are their pathogenic effects detectable.

The idea of vertical transmission of oncogenic viruses was suggested by Gross.[18, 19, 22] As with other pathogenic agents which are submicroscopic and do not always cause symptoms of disease, isolation and identification of oncogenic viruses may well escape the most careful and painstaking effort.

Speaking of the virus theory of cancer, Gross has made this statement: "There may exist a group of submicroscopic, cell-free, oncogenic agents, individually distinct, though possibly related, which may be transmitted vertically, i.e., from one generation to another."[20]

Existing in an inactive form, these agents would be moderate in their requirements and cause no apparent harm to their carrier hosts, Gross points out. Then, occasionally, these masked viruses might change into active disease-causing agents through some as yet unidentified mechanism. Stimulated into action by unknown stimuli, they might cause a cell to multiply rapidly as a variant of itself recognizable as a leukemic cell or tumor cell, depending on the place of origin. In laboratory animals and fowls already studied, and possibly even in man, this might occur at an age when offspring have already been produced, and the agent has already been passed along to the progeny.

If this hypothesis proves correct for man, it might be found that an oncogenic virus could pass through several successive generations without revealing its presence through disease symptoms.

Gross views this possibility in this way: "One can imagine that a hypothetical oncogenic agent might have caused a tumor in a distant ancestor perhaps two or three centuries ago. The virus could then have passed without causing any harm, through the great-grandfather, then through the grandfather and might have caused a tumor in the father. Accordingly, in the human host, one century, or even two, might conceivably elapse between successive cases of tumor or leukemia due to the same agent and transmitted from one generation to another."

To demonstrate this in human beings, however, would be most difficult, if not impossible. Similar problems to those that have faced geneticists in exploring the possible heritable characteristics of cancer would present themselves. What may be done with the mouse, with its short life span, cannot be done with man. Reliable statistics for specific causes of death such as leukemia over several generations, spanning at least a half century, would be a first, but formidable step. Leukemia was recognized as a disease only in 1845.[4, 10] Good pathological evidence to support case-finding has been a relatively recent development.

VIRUSES ARE ELUSIVE

An even greater problem is the elusiveness of cancer viruses. Because of lysogeny, in which a virus enters a cell and becomes a part of, or at least intimately related with, the cell's hereditary mechanism, and the well-recognized phenomenon of transduction—the transfer of hereditary material from one cell to another—the result of the virus' presence may be seen, but not the means.

Instead of destroying the cell immediately, as is the case with some nononcogenic viruses, the cancer virus may go "underground" and elude, for a time, the best efforts of investigators to detect it in the cell nucleus.

Until this riddle is solved, we cannot establish firmly the viral etiology of human cancer. The evidence for cancer-causing viruses in many other species than man is clear. So far, viruses which produce tumors have been isolated or identified in chickens, frogs, mice, rats, rabbits, hamsters, deer, and even fish.[39]

VIRUSES MAY CAUSE CANCER

The accumulation of evidence of animal cancer viruses spans more than half a century. The discovery that filterable viruses are capable of inducing cancer in animals was already 40 years old before the attention of medical science was seriously directed to the hypothesis that a relationship between human cancer and viral agents exists.

The late Dr. Duran-Reynals was among the first to suggest that viruses may be involved in human cancer, and he continued to voice his beliefs over many years, in the absence of any supporting evidence.

Nobel Laureate Wendell Stanley also was one of the first authorities to state his firm belief in a human cancer viral etiology. In 1952, he said that it was possible to make a reasonably good case that viruses might be important in human cancer. In 1956, he made this statement: "Basic biologic phenomena generally do not differ strikingly as one goes from one species to another, and I regard the fact, now proved beyond contention, that viruses can cause cancer in animals, to be directly pertinent to the human cancer problem."

Stanley's words were particularly important because of his vast experience in virology and his immense achievement in isolating the tobacco mosaic virus, for which he was awarded the Nobel Prize in 1946.[34]

Most recently, at the annual American Cancer

Society Science Writers' Seminar in California, Dr. Stanley said nothing has happened since 1956 to make him alter his opinion. "I still feel that we should assume that viruses, in one form or another, are implicated in human cancer," he said.

Although to date attempts to associate viruses with human cancer have not been successful, some remarkable clues exist as to this association.

Grace and his colleagues[16] at Roswell Park Memorial Hospital observed a tumor incidence of 17 per cent in Swiss mice injected at birth with a filtrate of human leukemic tissues, whereas filtrates of normal tissues failed to produce tumors in control mice. A filtrate prepared from the resulting mouse tumors has been maintained through six passages. Agents believed responsible for the tumors have been observed under the electron microscope. Although admittedly the human extract may have activated a mouse virus, the possibility still exists that a virus from human cancer has been observed. Continued studies are underway to attempt to isolate the factor and further identify it.

Schwartz and his co-workers[32] at Hektoen Institute in Chicago produced a cell-free filtrate from human brain tissue of leukemic patients and increased the incidence of leukemia in a low-leukemic strain of mice by injections of the agent.

DeLong[12] at the University of Toledo reported a similar result by injecting filtrates prepared from bone marrow cells from four types of human leukemia. A high incidence of leukemia in a low-leukemia strain of mice resulted. Controls injected with filtrates from humans free of disease were negative. About 20 per cent of the mice developing leukemia also developed other neoplasms.

Bergoltz[5] in the Soviet Union also reported having induced leukemia in mice with extracts from human leukemia.

Toolan and others[37] at Sloan-Kettering Institute have isolated from human tissue grown in vitro a cell-free filtrate which produces abnormalities when injected into hamsters at birth. Although no neoplasms have been induced, a condition resembling mongolism regularly results from infection by the agent. Attempts to find the virus in surgical specimens of tumor tissue from cancer patients were unsuccessful. But the abnormality in hamsters could be induced by fractions from the livers or spleens of humans or rats with spontaneous cancer.

Another outstanding virologist, Sarah Stewart at the National Cancer Institute,[36] added some new circumstantial evidence to the search for human oncogenic viruses when she reproduced bone lesions in experimental animals with a cytoplasmic virus extracted from tissues of a child at first believed to have an osteogenic sarcoma but later shown to be suffering from Hand-Schüller-Christian disease, a member of the histiocytosis-X group, which includes both benign and malignant manifestations.

EARLY IDENTIFICATION POSSIBLE?

Another important step in virus research was taken in 1962 by a brilliant young scientist working in California under a grant from the American Cancer Society. His studies have been done with chickens, but his results might open doors for human-virus researchers. Dr. Harry Rubin, working in Stanley's laboratory,[28] has developed a simple test for detecting a virus which causes lymphomatosis, a type of leukemia in chickens. The test reveals the presence of the virus before it shows any other signs of its whereabouts, and before it causes any disease symptoms in the host chicken.

The test is based on an interference principle: that is, it interferes with the action of another chicken cancer virus, the Rous sarcoma virus. Rous virus will cause chicken embryo cells to appear abnormal, in tissue culture; but if lymphomatosis virus is also present, the Rous virus is prevented from acting: no abnormality can be seen (a case where two positives make a negative). The test is quick and efficient. This finding will undoubtedly aid the poultry industry, where lymphomatosis is a costly killer of chickens. Now, apparently healthy chickens can be removed from the flock if virus is detected in their serum.

But perhaps more important is the hope that what Dr. Rubin has done for chickens may be done for human beings in the future. If a human cancer-causing virus could be detected before it begins its malignant action, a revolution in cancer control would take place. Out of the laboratories of virologists, biochemists, and immunologists might come undreamed-of new techniques for fighting cancer. Chemical blocking substances might be designed to stop viruses from sequestering inside cells, crippling the lurking virus before any sign of disease appears. Or some immunological device might be developed to protect the host from the future ill effects of offering room and board to apparently benign but potentially harmful virus particles.

All of this, of course, is only a beginning. Vast knowledge needs to be acquired before viruses can be implicated in human cancer. Still there will be a tremendous challege, to find means of either altering the oncogenic virus or inhibiting its effects.

One obvious area of attack is the possibility of inducing the human organism to produce antibodies against the virus invader. However, still there would be many problems. Even if oncogenic

circulating antibodies do exist in man or could be stimulated, it is probable that the cancer virus will remain secure in its stronghold. Present knowledge indicates that antibody reaction operates at the extra-cellular level. Furthermore, it is believed that the immune stimulus occurs when the protein shell of the virus reacts with cellular materials. If the Gross postulate is correct, and human oncogenic viruses *are* transmitted as part of or attached to nucleic acids of the germ cells, a new and vastly complex problem in immunity will be presented.

There is little doubt that the whole problem of antigenicity will require vigorous research before final answers can be found. The role of chemotherapy in attacking viruses will likewise need wider exploration. Still, it seems probable that in these directions, new means of controlling neoplastic growth in man may well be found. ■

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Urinalysis revealed one case of diabetes and fasting blood sugar disclosed ten; postprandial level was the best screen.

Detection of Latent Diabetes Mellitus in a Chronic Disease Hospital

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• *Early detection of diabetes mellitus offers the only hope of preventing or minimizing late complications of the disease. Urinalysis is a wholly ineffective screening test, and in this chronic disease hospital population only half the diabetics had an abnormal fasting blood sugar level. Postprandial blood sugar level was the best screening test, and the two-hour glucose tolerance test the best diagnostic procedure. Among 243 admissions in two calendar years there were 16 known diabetics and an additional 19 were found by this investigation.*

PREVAILING opinion defines diabetes mellitus as a genetically determined systemic disease complex producing a variety of syndromes during its evolution from birth to the chronic diabetic state.[1, 2] It was only a few years ago that diabetes was considered simply as a disorder of carbohydrate metabolism. Today there is a growing conviction that this metabolic disorder is only one facet of the total diabetic syndrome, and that there are other unknown factors in the pathogenesis of this disease complex.

By the time diabetes becomes clinically evident as hyperglycemia and glycosuria, it is now generally felt, the vasculature has already suffered damage which eventually will manifest itself as late complications. The vital question to the practicing clinician is whether early detection and early treatment will significantly alter the development of these late complications. The preponderance of opinion appears to be that good management at the early or latent stage will prevent or retard, to some degree at least, the progress and development of the complications.[3] If so, it is our responsibility to try to detect diabetes at the earliest stage now possible.

The purpose of this paper is to present two years of experience in the detection of the latent diabetic state in a chronic disease hospital and to discuss the criteria used to screen and to diagnose the latent diabetic stage.

METHOD AND MATERIALS

There are two methods in general use to determine the concentration of blood sugar.[4] The first method measures selectively the blood glucose's reducing power and is referred to as the "true blood sugar." This is determined by the Somogyi-Nelson method. The second method

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Submitted for publication November 13, 1963.

measures the blood's total reducing power and is affected by such substances as glutathione, ascorbic acid, and others. It is determined by the Folin-Wu method and is commonly accepted to be approximately 20 mg/100 ml higher than the corresponding concentration measured by the Somogyi-Nelson technique. The present report is based on the Folin-Wu method of determination.

The screening device used was the postprandial blood sugar test, with the venous whole-blood sample taken one and a half hours after a high carbohydrate meal. The blood sugar concentration chosen as indicating a diabetes suspect was 150 mg/100 ml. The screening test was performed within the first few days after admission to the hospital. When the result was 150 mg/100 ml or over, a standard oral glucose tolerance test was performed using only 50 grams of glucose as the loading test (we have since changed to 100 grams of glucose).

The population screened consisted of patients who were admitted to Samuel Mahelona Memorial Hospital during 1961 and 1962. These patients were all ambulatory. They were admitted for variety of reasons, such as suspected pulmonary tuberculosis, mental illness, other types of chronic respiratory illness, and for short-term diagnostic evaluation.

RESULTS

During 1961 and 1962 there were 243 admissions, of which 18 were readmissions and 16 were known diabetics. The remaining 209 patients were screened with the one and a half hour postprandial blood sugar test determined by the Folin-Wu method on venous whole-blood samples. In 27 patients blood sugar concentration was 150 mg/100 ml or above; 23 of these patients had follow-up with the standard oral glucose tolerance test. Of these, 16 patients were considered to have a characteristic diabetic curve according to criteria to be presented later. Two patients were recalled because of normal curves and were given the cortisone–glucose tolerance test with the result that one was "compatible with" diabetes and one was considered "probable" diabetes. Another patient with a "probable" diabetic curve was not recalled for the steroid-modified glucose tolerance test. Three patients with abnormal carbohydrate tolerance curves were eliminated because of the presence of cirrhosis of the liver in one patient (confirmed by autopsy) and of bronchogenic carcinoma in two patients (confirmed by autopsy). These patients showed no diabetic stigmata in histological examinations.

Only one patient was considered to have a negative glucose tolerance test but a curve which was not normal. This patient had bronchogenic carcinoma, with a screening postprandial sugar level of 166 mg/100 ml and a glucose tolerance test showing a fasting blood sugar level of 128 mg/100 ml, one hour 156 mg/100 ml and two hours 150 mg/100 ml.

The net result of the 23 patients followed up with the standard and the steroid-modified glucose tolerance test showed 19 patients with results compatible with the diagnosis of diabetes mellitus or probable diabetes, for a rate of approximately nine per cent.

The remaining four patients who could not be followed up with the glucose tolerance test consisted of three patients who later died. Autopsy findings were cirrhosis in one patient, pancreatitis in the second patient, and bronchopneumonia in the third patient, who had a family history of diabetes. The fourth patient was in the hospital only a few days and then left the island.

It is interesting to note that of the 19 patients diagnosed as having diabetes, only one patient had a fasting glycosuria and nine had a fasting blood sugar of 120 mg/100 ml or less. Thus, approximately 50 per cent of the diabetics had a normal fasting blood sugar.

The types of disease associated with known and newly discovered diabetes were as follows: 16 patients had inactive or active pulmonary tuberculosis, eight had psychiatric conditions, and 11 had other chronic chest conditions such as bronchiectasis, asthma, etc.

The ethnic distribution (no statistical significance is intended) was as follows, based on the number of admissions: there were seven newly discovered and six known diabetics among 70 Japanese admitted during the two years; there were ten newly discovered and five known diabetics in 99 Filipinos admitted; there were four known diabetics in Hawaiian and part-Hawaiian out of 24 admissions; there were two newly discovered diabetics in Chinese out of four admissions; and only one known diabetic in Caucasians out of 22 admissions.

LATENT STAGE DETECTABLE

With the general concept of diabetes changing from a simple disorder of carbohydrate metabolism to a complex generalized disease, it has become imperative to make a diagnosis of the diabetic state as early as possible. Of vital concern to the practicing physician is that early detection with early treatment offers the only hope today to prevent or retard, to some degree at least, the development of late complications. Although we have no proven simple tool at the present time to detect the "prediabetic" state, we do have one to detect

the latent or chemical stage of diabetes mellitus. Latent diabetes can be detected by screening with appropriate postprandial blood sugar test and the diagnosis confirmed by the standard oral glucose tolerance test.

Diabetes mellitus is considered to be genetically determined, with the basic abnormality present at conception. It is now considered that patients pass through the "prediabetic" state, which is defined as the period of time from conception to the time when diminished insulin activity can be demonstrated,[1] through the latent phase when the faulty carbohydrate metabolism first becomes evident, through the clinical or overt diabetic stage, and finally, to the chronic phase with late complications. The transition from "prediabetic" to the latent phase is still indefinite.

The hallmark of latent diabetes is the demonstration of an abnormal glucose tolerance curve, often with a normal fasting blood sugar. Diabetic complications frequently occur in latent diabetic stage[2] which is another important reason for early detection.

There are several ways to screen for unknown diabetes. In a comparative study of urine and blood test in detecting diabetics, there was little question that blood test proved superior to urinalysis.[5, 6] It discovered over twice as many new cases of diabetes.[7] This correlates with the present two-year period of study in which only one case of newly discovered diabetes had glycosuria.

Urinalysis will therefore miss a significant number of latent diabetics.[8] However, urinalysis is not the only unreliable test still used to find diabetics. Many physicians continue to employ the fasting blood sugar test to diagnose the condition.[9] This method of screening or diagnosing unknown diabetes has been repeatedly pointed out to be undesirable and recommended to be abandoned.[2, 10, 11] If the fasting blood sugar is used, it has been shown to produce the lowest yield.[5, 12] Approximately 50 percent of patients diagnosed as diabetic had fasting blood sugar concentration of less than 120 mg/100 ml in the present study.

POSTPRANDIAL BLOOD SUGAR SCREEN

With the blood test proven to be superior in screening for unknown diabetes, it has been shown that the postprandial blood sugar method is the best screening test. The postprandial blood sugar method, with the Clinitron, proved to have the highest relative sensitivity in detecting unknown diabetes, and equally good relative specificity as compared with other methods used.[7] It also uncovered twice as many new diabetics.

The time when blood sugar is taken in relation to food is important. Packer, Ackerman, and Hawkes[12] have shown that the highest yield of new cases was observed when the test was performed between one and two hours after eating. This interval also produced the lowest percentage of false positives. This is an important point to consider, for a good screening test should be easy to perform and should be sensitive enough to miss a few persons and yet specific enough to avoid creating a large number of false positives.

In the present study, blood sugar was taken one and a half hours postprandially. Of 27 diabetes suspects, 23 had glucose tolerance tests, only one of which could be considered negative. The other three patients with abnormal glucose tolerance test, were considered nondiabetic for the purpose of this report because of the presence of cirrhosis or neoplasia.

A two-hour postprandial blood sugar test with the blood level of 140 mg/100 ml (Folin-Wu method)[12] has been recommended as a screening procedure. This would probably be just as reliable, and studies have shown this method would detect nearly all the diabetics who were confirmed by the standard glucose tolerance test.[5] This method is considerably more sensitive and specific than urinalysis. The American Diabetes Association recommends that the two-hour postprandial blood sugar of 110 mg/100 ml by the Somogyi-Nelson method or 130 mg/100 ml by the Folin-Wu method be considered as suggestive of diabetes.[13] The two-and-a-half-hour postprandial test has been found to be less satisfactory.

In surveys using the Clinitron, which measures the "true" blood sugar level as determined by the Wilkerson-Heftmann method, it was found that 130 mg/100 ml was the optimum level in case-finding when the test was performed between one and two hours after eating.[12] This level corresponds to a 150 mg/100 ml level as determined by the Folin-Wu method. This was the level used in the present study. At the present time I am evaluating the 140 mg/100 ml level; Wilkerson and others[14] have found that when the one-to-two-hour postprandial venous blood sugar level is between 140 and 169 mg/100 ml (Folin-Wu method), diabetes developed eight times more often than in a normal control group reviewed seven years later.

GLUCOSE TOLERANCE TEST BEST

The cornerstone in the diagnosis of diabetes mellitus is the standard oral glucose tolerance test. It is recommended that high carbohydrate diet precede the glucose tolerance test. The criteria used in the present study are those of Conn and Fajans as presented below, but differ in that no effort was made to give the antecedent three-day

TABLE 1.—*Normal values for the standard oral glucose tolerance test.*

	CHEMICAL METHOD	BLOOD SUGAR VALUES, MG/100 ML OR LESS			
		Fasting	*1 hour*	*1½ hours*	*2 hours*
ADA	Somogyi-Nelson	110	150		110
	Folin-Wu	130	170		130
Conn & Fajans	Somogyi-Nelson		160	135	110
	Folin-Wu		180	155	130

Abnormal values for the standard oral glucose tolerance test.

	CHEMICAL METHOD	BLOOD SUGAR VALUES, MG/100 ML OR MORE			
		Fasting	*1 hour*	*1½ hours*	*2 hours*
ADA	Somogyi-Nelson		160		140
	Folin-Wu		180		160
Conn & Fajans	Somogyi-Nelson		160	140	120
	Folin-Wu		180	160	140

high carbohydrate diet. This apparently is not absolutely necessary,[15, 16] although such a measure would make the test results more reproducible.

All experts agree that the standardized oral glucose tolerance test is the most sensitive diagnostic index when properly performed. Crucial to the diagnosis are the criteria for and the interpretation of the normal glucose tolerance curve. That the criteria and interpretation will vary from clinic to clinic is well known. However, at the present time, all experts agree that the diagnosis of diabetes mellitus can be made in a completely asymptomatic patient by a carefully administered glucose tolerance test when the following curve is obtained by the Somogyi-Nelson or the "true" blood sugar method: fasting 80 mg/100 ml, one hour 160 mg/100 ml, one and a half hours 150 mg/100 ml, and two hours 140 mg/100 ml, provided other causes of decreased carbohydrate tolerance are ruled out. This can be converted to equivalent values determined by the Folin-Wu method by adding 20 mg/100 ml as follows: fasting 100 mg/100 ml, one hour 180 mg/100 ml, one and a half hours 170 mg/100 ml, and two hours 160 mg/100 ml.

Conn and Fajans believe that the diagnosis can still be made by lowering the two-hour value from 140 mg/100 ml to 120 mg/100 ml ("true" blood sugar). Apparently most workers agree that the two-hour level can be lowered to include a large number of patients formerly designated as "potential" diabetics, but there is some reluctance to accept the 120 mg/100 ml criteria. Based on their extensive experience with the standardized oral glucose tolerance test, Conn and Fajans now believe that diabetes mellitus exists when the glucose tolerance curve falls at or above the following criteria (converted to Folin-Wu values): one hour, 180 mg/100 ml, one and a half hours, 160 mg/100 ml, and two hours 140 mg/100 ml. Our criteria are based on these levels. Table 1 shows the criteria for normal and abnormal curves recommended by American Diabetes Association in 1963, and by Conn and Fajans, and also based on the type of chemical method used.

Mosenthal and Barry,[17] in their classical work on the criteria of a normal glucose tolerance curve, stressed the height of the blood sugar as a necessary element for the diagnosis of diabetes when combined with the two-hour level. The peak usually occurred in the half-hour specimen after the glucose loading test. When their work is examined at the one-hour and two-hour periods, one notes that the values are consistent with the Conn and Fajans criteria.

In evaluation of the glucose tolerance curve, therefore, it is essential to take into consideration the blood sugar levels at *one hour AND two hours*, and, if the curve is borderline, the one-and-a-half-hour level.[18] The one-and-a-half-hour level should be between 155 and 160 mg/100 ml and the two-hour level between 120 and 140 mg/100 ml (Folin-Wu) for a diagnosis of "probable" diabetes. Some workers have even recommended that the test be extended to the fourth and fifth hour after the glucose loading test to detect the hypoglycemic level characteristic of potential diabetes.[19] Occasionally one will see a high one-hour level and a normal two-hour level. This is not abnormal, but represents rapid absorption from the gastrointestinal tract. On the other hand, there may be a normal one-hour level and an elevated two-hour value, which is also not abnormal, but denotes delayed absorption from the gastrointestinal tract.

In the interpretation of the glucose tolerance curve, it is important to know the method used to determine the blood glucose concentration and also the conditions which may produce a high and prolonged curve unrelated to diabetes.[19] In using the Folin-Wu method of blood sugar concentration, as in the present study, the reducing substance may vary widely as much as 70 to 80 mg per cent.[16] However, it is usually accepted that the difference between the Somogyi-Nelson method and the Folin-Wu method is about 20 mg per cent.

Nondiabetic conditions which may produce a high and prolonged curve include liver disorders, endocrinopathies, neoplasia, stress, and various drugs.[19] There were two patients with cirrhosis who had elevated postprandial blood sugar. One patient subsequently was found to have an abnormal glucose tolerance curve. There were four patients with bronchogenic carcinoma who also showed elevated postprandial blood sugar. Two of these patients had a glucose loading test performed and the curves were diabetic in type. Neoplasia is known to alter carbohydrate metabolism.[20] These patients were not regarded as latent diabetics in our study and the postmortem examination failed to produce any pathological findings characteristic of diabetes mellitus.

SUMMARY AND CONCLUSIONS

In terms of public health, diabetes is becoming a larger problem than all the other endocrine diseases combined. Diabetics are living longer and diabetes is apparently increasing. There is increasing awareness that complications may be present without the characteristic symptoms of clinical diabetes. Detection and treatment of early diabetes offer the only hope at this time to prevent or retard, to some degree at least, the late complications.

We have a simple and sensitive screening tool to detect early diabetes, namely, the postprandial blood sugar test. We have also the standard oral glucose tolerance test, which is the most sensitive test and is relatively easy to perform in any laboratory, to confirm the presence of diabetes mellitus.

The interpretation and criteria used to diagnose diabetes are discussed. Both one-hour and two-hour values must be elevated for the diagnosis of diabetes and, if the curve is borderline, the one-and-a-half-hour level must be considered. It is important to know the laboratory method used to determine the blood sugar concentration in evaluating the glucose tolerance curve. Not all high and prolonged curves, however, mean that diabetes is present. There are many nondiabetic conditions which may alter the carbohydrate metabolism.

A detection program for latent diabetes mellitus in a chronic disease hospital is presented. ■

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Childhood tuberculosis is decreasing on Kauai, but the Waimea district still has more than its share of the 30 or so who "convert" annually.

Kauai School Tuberculin Testing Data

An Epidemiologic Analysis

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• *Filipino children on Kauai, especially in the Waimea-Kekaha district, have a higher incidence of tuberculous conversion than children of other racial groups or in other districts, probably because of exposure to tuberculous Filipino men who are not now cooperating with the chest x-ray surveys.*

KAUAI has had an annual high school tuberculin testing program from 1952 through 1958, and since then it has had a tuberculin testing program that covers all school children at least every second year. This paper is an attempt to describe some aspects of tuberculosis epidemiology on Kauai through the analysis of the accumulated tuberculin testing data from 1952-1963.

CASE-FINDING METHODS

In order to evaluate case-finding methods, Tuberculosis Association, Health Department, and Mahelona hospital records were examined in 1958 and again in 1963. The changing relative effectiveness of case-finding methods from 1955 to 1963 is shown in Table 1. As is true of any new case-finding effort, the school tuberculin testing program skimmed the cream off the surface during its first year, finding three active child cases and nine active adult cases (contacts) in 1952. Since then, its case-finding effectiveness has fallen to zero, even though the program has been expanded in recent years so that it covers about 90 per cent of all school children on the island. During 1959-1962, there were five children diagnosed with pulmonary tuberculosis—two were recent immigrants from the Philippines (one reported by the USPHS and one by the local doctor), and three were Kauai children (all reported by local doctors).

In recent years the Kauai annual chest x-ray survey has continued to cover about 70 per cent of all adults each year, but its relative effectiveness as a case-finding method has also fallen, leading one to the suspicion that most old, inactive cases of tuberculosis have been identified in the surveyed population and referred to Chest Clinic for follow-up (note the relative increase in effectiveness of the Chest Clinic). This is in agreement with the "Kauai X-ray Survey Participation Study,"† which suggests that the adults seen each year in the x-ray survey are the same people each year, and that there is very likely a "hard core" of about 3,500 adults who seldom if ever participate. Cases arising from the unsurveyed part of the population would most likely be discovered by the local doctors and hospitals, which, as we can see from Table 1, are assuming a relatively more important role in case finding.

TABLE 1.—*Case-finding methods used to discover newly-reported cases of tuberculosis, Kauai.*

CASE-FINDING METHOD	% OF ALL CASES DISCOVERED		1959-1962 35 SPUTUM-POSITIVE CASES (8.75/YEAR)
	1955-1957 206 cases (69/year)	*1959-1962 142 cases (35/year)*	*% of sputum-positive cases discovered*
Chest x-ray survey	68%	25%	11½%
School tuberculin testing and contact investigation	2½%	0%	0%
Chest Clinic—following old inactive cases and contact investigation of active cases	14½%	39%	39%
Physicians and general hospitals	15%	30%	40%
U.S. Public Health Service	0%	6%	9½%
Total	100%	100%	100%

REVIEW OF TESTING DATA

Analysis of tuberculin testing data is always subject to error due to changes in criteria for "positive," changing tuberculin material, changes in technique or personnel, or changes in reporting habits of the persons reading the tuberculin tests.

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(Report No. 8 from the Pacific Biomedical Research Center.)

† Betty MacLean, Hawaii State Tuberculosis and Health Association, December 26, 1962.

The Kauai data are unusually "clean," in that technique and tuberculin material have not changed since 1953, changes in criteria for "positive" have not changed since 1955, the same Public Health Nursing Supervisor has been in charge of the program throughout, and her nursing staff has had a very low turnover rate during the past ten years. In 1952, .0005 mgm of PPD was used in a standard intradermal 0.1 ml test, but since then .0002 mgm of PPD has been used. The criterion for positive reactions was an induration of 5 mm or more in diameter during 1952-1955, but it has been 6 mm or more of induration since then. The readings by diameter are available for 1961, 1962, and 1963; so curves were drawn for these years by diameter of induration reported for each child by age, sex, geographical district, and person reading the test. These curves showed an exceptionally flat "tail," with no deep notch to tell one whether "positives" should be called at 6 mm (as is done on Kauai) or at 8 mm (as is done on Oahu). Because of this flat tail, it was necessary to do subsequent analyses using both 6 mm (Kauai) and 8 mm (Oahu) criteria to see if the observed patterns would be consistent. They were, regardless of the criterion used. A preliminary look at both high school (1952-1963) and elementary school (1958-1963) data showed the following consistent patterns:

1) Highest rates among Filipino children, followed in descending order by the Hawaiian–part-Hawaiians, the "Others," the Japanese, and the Caucasians.
2) For each racial group, boys had higher positive rates than girls.
3) For each racial group the tuberculin positive rates for 1961-1963 (three-year mean) were lower than the mean values for the earlier years.

Part of this encouraging, if slight, decline in tuberculin-positive rates was undoubtedly accounted for by the changing of the "positive" criterion of 5 mm to 6 mm after 1955, but part of it may well represent a genuine reduction in the amount of tuberculous exposure of the children, since the amount of decline was different in different racial groups.

These preliminary observations could be distorted by changes in the composition of the school population; so all school tuberculin testing records for 1959-1963 were re-analyzed, using 6 mm as the "positive" criterion, and rate curves were drawn by age, race, and sex (Figure 1). These curves support the preliminary impression, and show that for children under 10 years of age, racial differences are more important than sex, with Filipino children starting with positive rates of about

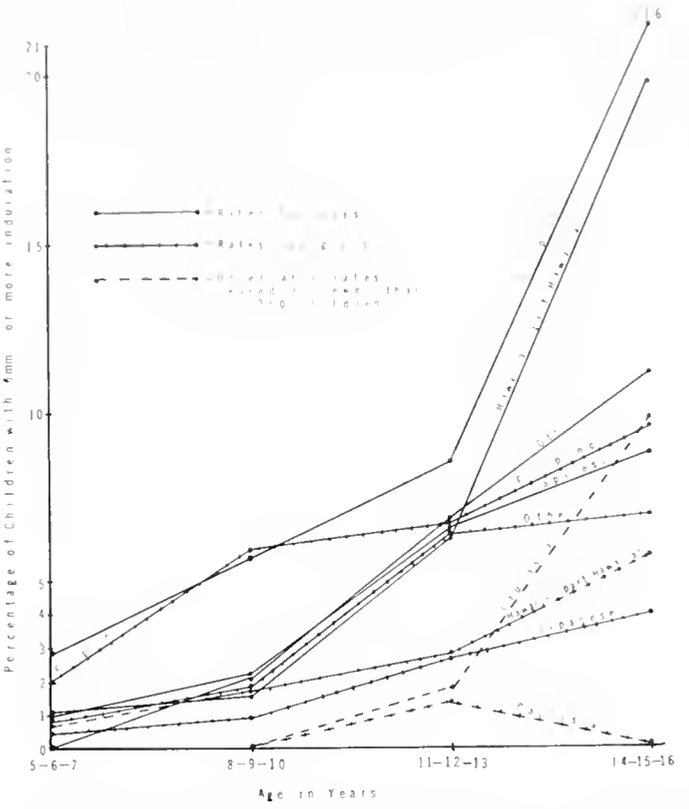


FIG. 1.—*Tuberculin-positive rates by age, sex, and race, Kauai School Tuberculin Testing Program, 1959-1963 averages.*

two per cent at six years of age and rising to six and one-half per cent by age nine, while all other children, regardless of race or sex, are clustered below one per cent positive at age six, rising to the neighborhood of two per cent by age nine. By age 12 sex differences are beginning to appear and are fully apparent by age 15, when all the girls (except Filipino) are below seven per cent positive, Japanese and "Other" boys (and Filipino girls) are clustered around 10 per cent, and Filipino and Hawaiian–part-Hawaiian boys are clustered around 20 per cent positive. These three clusters of positive rates are all reliably different from each other at the five per cent level of significance, as are the differences observed between Filipino children and all other children at the younger ages (six and nine).‡ Therefore, if we make the assumption that boys and girls are equally able to convert to tuberculin positive if given equal exposure to the tubercle bacillus,§ and

‡ $$Z = \frac{P_1 - P_2}{\sqrt{\frac{pqN}{N_1N_2}}}$$

§ This assumption can be tested by analogy through examination of the BCG trial data of the British Medical Research Council, in which 3,712 tuberculin-negative boys and 3,621 tuberculin-negative girls were given equal doses of BCG and were then tuberculin tested again in the next few months. At 3 T.U. 88.5 per cent of the boys had become positive, but only 79.9 per cent of the girls. This small difference is statistically reliable, and might indicate that the boys might be slightly more able to "convert" than the girls. These data may be slightly biased, however, since the boys were given BCG on their arms, while the girls received theirs on their thighs. (Ian Sutherland, British Medical Research Council. Personal communication.)

that there are no racial differences in this ability, it must follow that the chief cause of tuberculin positivity should be found in Filipino homes and in the nonhome, nonschool environment of adolescent Filipino and Hawaiian–part-Hawaiian boys.

Is this source of infection more likely to be the tubercle bacillus in cases of active pulmonary tuberculosis, or some other mycobacterium in the environment? It is difficult to think of some other soil or animal mycobacterium that would fit the above epidemiologic pattern. On the other hand, it is very reasonable to expect this pattern if the chief source of infection is older men, particularly Filipino men, especially if we make the reasonable assumption that older boys are more likely to venture out into the society of older men than are older adolescent girls. Data to be presented below will support the reasonableness of this assumption.

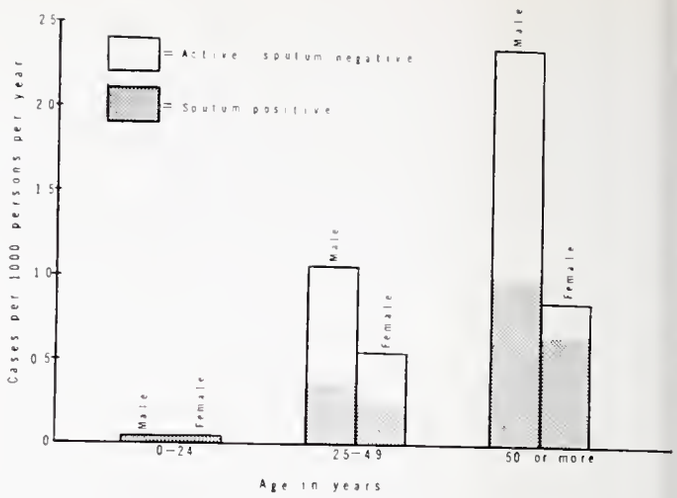


FIG. 2.—*Newly reported active cases of tuberculosis by age and sex, County of Kauai, 4-year average, 1959-1962.*

GEOGRAPHICAL DIFFERENCE

But first, is there a difference of exposure to tuberculosis in the different districts of Kauai? An examination of the annual reports of the school tuberculin testing program by school for 1959-1963 shows a fairly consistent rate of tuberculin "positivity" among elementary school children at about three per cent, but with higher rates found in the "westend" elementary schools (both public and Catholic), which average at about eight per cent. The two eastside high schools average at about nine per cent positive, but the Waimea High School averages at about 15 per cent.

Part of this geographical difference might be explained by differences in age and racial composition of the various schools; so tuberculin positive rates were calculated by age, sex, and race for the three main districts of Kauai—northeast, central, and southwest. The only marked deviations noted from the island-wide curves presented in Figure 1 were for the southwest area (Eleele to Kekaha), where all the positive rates were above the island averages by age, race, and sex, especially in the children over age 10. Caucasian and Hawaiian–part-Hawaiian numbers are too small for reliable comparison, but for Filipino, Japanese, and "Other" children the tuberculin positive rates in the southwest area for ages 14-16 are reliably higher (at the five per cent level of significance) than the corresponding island-wide rates, with a high rate of 30 per cent positive for Filipino boys, ranging down to eight per cent positive for Japanese girls.

It should be remembered that these results are from tuberculin tests given and read by the same group of nurses, using the same equipment and technique, and very often done at the same time as children in other areas (i.e. Lihue Catholic schools and all Koloa and Kalaheo schools are done at the same time as the Eleele to Kekaha schools). Therefore, it is hard to escape the conclusion that the children in the southwest area, especially in Waimea and Kekaha, are at greater risk of exposure than children on the rest of the island.

Finally, a statement about the numbers and types of people presumably causing this exposure of the children of Kauai. If you define a "converter" as a child who had a tuberculin reaction of 5 mm or less at one time and had a reaction of 6 mm or more the next time tested, it can be crudely estimated that there are about 40 such conversions in the school-age population per year. If you use an 8 mm reaction as the criterion for a conversion, there are about 25 conversions per year in the school-age population.

During 1959-1962 hospital and chest clinic records show a total of 35 new sputum-positive cases of tuberculosis reported on Kauai (average of 8.75 cases per year or 0.31/1000 population/year). The same records reveal a total of 77 new cases diagnosed as active or sputum-positive pulmonary tuberculosis (average of 19.25 cases per year or 0.68 cases/1000 population/year). These cases are presented graphically in Figure 2 by age and sex and in Figure 3 by race and sex. Unfortunately 1960 census data are not such that rates can be calculated by age, race, and sex simultaneously. These figures show clearly that active or sputum-positive tuberculosis on Kauai is predominantly an adult male disease, especially prevalent in men over 50 and in Filipino men. If to the nine "new" sputum-positive cases identified on Kauai each year are added about five reactivated known cases who become sputum-positive, there would be a total of about 14 known sputum-positive cases discovered each year. If each of

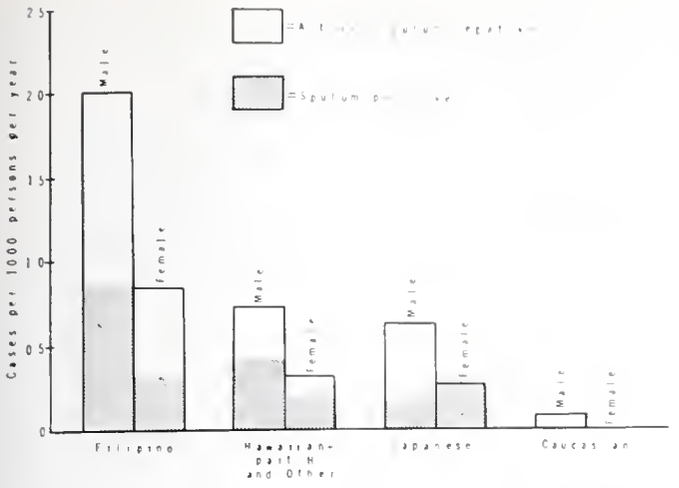


FIG. 3.—*Newly reported active cases of tuberculosis by race and sex, County of Kauai, 4-year average, 1959-1962.*

these cases were sputum-positive long enough to cause the "conversion" of only two or three school children during the period before isolation, then the entire volume of tuberculosis being transmitted to the school-age population on Kauai could be accounted for by this one source. These are not unreasonable assumptions; so we do not have to postulate a large number of undiscovered infectious cases of tuberculosis among the 3,500 or so of Kauai's adult population who do not participate in the annual chest x-ray survey, nor do we have to postulate conversions due to other mycobacteria in the environment.

DISCUSSION

Tuberculosis workers on Kauai have known for some time that most of their active tuberculosis is being identified among the elderly male population, especially among the Filipinos who came to Kauai after a childhood spent in a highly tuberculous environment in the Philippines. Unfortunately, when the public health nurses on Kauai try to trace the contacts of school children who have "converted," they find it almost impossible to get the mothers to name any contacts other than those people living in the immediate household, for fear of antagonizing the persons named. It seems clear that a considerable proportion of tuberculosis transmission is taking place outside the home, from older men to adolescent boys, and this may explain why the school tuberculin-testing program has not been a productive case-finding method.

SUMMARY AND CONCLUSIONS

Kauai High School children have been tuberculin tested annually from 1952 to 1958, and 90 per cent of all school children have been tuberculin tested at least every second year from 1959 to 1963. An analysis of these data and Mahelona Hospital and chest clinic records lends support to the following conclusions:

1. There is probably a slight decrease in tuberculin-positive rates among school children on Kauai during the past decade.
2. Among children under 10 years of age, Filipino children of both sexes are at greater risk of tuberculosis infection than are other children of the same age, among whom neither racial nor sex differences are important.
3. By age 14-16 strong sex differences appear in tuberculin-positive rates, with boys at greater risk than the girls, especially Filipino and Hawaiian–part-Hawaiian boys. These boys are very likely getting their infections when they go out of their homes and associate with older men.
4. Children in the Waimea-Kekaha area, especially the children over 10, are at greater risk of tuberculosis infection than their counterparts on the rest of the island.
5. The school tuberculin testing program is not an effective case-finding tool on Kauai, largely because of the reluctance of people to name nonhousehold contacts of children who have converted to tuberculin positive.
6. About 14 new or reactivated sputum-positive cases of tuberculosis are reported on Kauai each year, and these could reasonably be expected to account for the total of about 30 school children who "convert" to tuberculin positive each year; so we do not need to postulate a large number of undiagnosed sputum-positive cases or to invoke nontuberculous mycobacteria.
7. The chest x-ray survey will probably play a declining role in tuberculosis detection on Kauai unless it can be expanded to include the 3,500 or so adults who do not participate in it at present, with every effort made to include elderly Filipino and Hawaiian–part-Hawaiian men, and every effort to expand coverage in the Waimea-Kekaha area.

ACKNOWLEDGMENTS

Acknowledgment is made of the financial support of the Hawaii State Tuberculosis Association and of the University of Hawaii Department of Public Health in carrying out this study. Acknowledgment is also made of the cooperation and assistance of the Department of Health, State of Hawaii, of the Hawaii State and Kauai Tuberculosis and Health Associations, and of the careful clerical work done on Kauai by Mrs. Evaline Malina. Special thanks are due to Dr. Robert Marks for his encouragement and advice. ■

Listeria monocytogenes caused fatal meningitis in a six-year-old child in Hakalau in 1948. Watch for it!

Human Listeriosis in Hawaii

Report of a Fatal Case

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• *Listeria monocytogenes, first isolated in 1918 from a fatal case of meningitis, was identified in 1926 as a cause of disease in rabbits. A small, Gram-positive, motile rod, it grows best anaerobically on blood agar. Heterophile antibody agglutinins occur in 75 per cent of cases. Over 500 human cases have occurred. Tetracyclines are more effective than penicillin. Sulfonamides are ineffective. The patient reported here died while seemingly recovering from Listeria meningitis.*

RECENT reports on listeriosis, coupled with the activities of the Pacific Research Section of the National Institute of Health on epidemiologic investigations of eosinophilic meningitis in the Pacific area, have prompted me to report a case of Listeria monocytogenes meningitis first observed on the sugar plantations and reported to the Department of Health in 1948.

Although to date this remains the only case on record in Hawaii,[1] judging from a review of the literature, this disease ought not be a rarity. It is the plea of the author that the entity should be more constantly borne in mind.

CASE REPORT

A six-year-old Japanese boy was admitted to the Hakalau Plantation Hospital on March 6, 1948, because of having had a stiff neck for one day. Symptoms began with a "cold" two weeks previously, with mild sore throat, and nasal blockage. Five days prior to admission, the cold got worse. Two days before admission, he developed a severe headache and awoke the next morning with a rigid, sore neck. There was fever (101°F), drowsiness, irritability, and poor appetite; no nausea or vomiting; regular bowel movements. Occasionally the patient would cry out and complain of pains.

Past history revealed what was supposed to have been "congenital heart disease," evidenced by a "bluish tinge" noticed by the parents when he was seven months old. The parents owned a meat market and this child was in and out of the premises at will, delighting to help his father with the work.

Physical examination showed an acutely ill child lying on his side, head extended, neck rigid, in semi-opisthotonus, crying and in pain. Temperature was 101°F, pulse 112, respirations 18. The skin was clear, without any rashes, petechiae, icterus, or pallor. Eyes, ears, nose, and throat showed nothing but nasal discharge. Cervical nodes were not palpable. The lungs were clear, free of rales or rubs. The heart gave a loud, blowing murmur at the precordium. The abdomen was soft and full, without tenderness or palpable masses. The spleen and liver were not enlarged. The knees were drawn up and spastic. Kernig's and Brudzinski's signs were positive, Babinski's sign was not demonstrated, and there was no calf tenderness. The fingers were clubbed.

A spinal puncture was done on day of admission. The pressure was normal, and 8 cc of clear fluid were withdrawn in two samples. Cell count was 31 per mm.^{3} Spinal fluid smear showed rare leucocytes, no organisms. Culture on blood agar showed no growth (72 hrs.); on chocolate medium, Gram-positive bacilli morphologically resembling Listerella monocytogenes were present. Second report four days later identified these as Listeria monocytogenes (Hilo Board of Health Laboratory).

Heterophile agglutination was positive 1-64 (March 11), and later positive 1-128 (April 1).

The leucocyte count rose from about 8,000 on admission to nearly 35,000 on March 30; a week later it had fallen to 11,000 (with 5 per cent eosinophiles) and on April 24 it was 6,000. The lymphocyte proportion rose from 15 per cent to 40 per cent as the count dropped, and only one abnormal lymphocyte was seen.

Spinal fluid was sterile on culture on March 20 and showed no organisms on smear; only six leuco-

Received for publication June 26, 1963.

cytes were seen, half of them polys; sugar was 6.6 mg per 100 cc and globulin was increased. On April 28, no cells or organisms were found in the spinal fluid.

Stool culture was negative for Listerella, and stool showed no ova or parasites.

This patient survived 52 days in the hospital, during which period he became afebrile and apparently improved daily while being treated with penicillin, streptomycin, sedatives, vitamins, and general nursing care. However, on the 49th hospital day, the patient began to have severe pains in the neck, coupled with episodes like syncope, which increased in severity and caused his death three days later. Unfortunately, a postmortem examination was declined.

Did he survive the infection to succumb to another entity? This will never be proved.

THE ORGANISM

In 1918, two Frenchmen, Dumont and Cotoni,[2] isolated a small Gram-positive organism in pure culture from a soldier who died of meningitis at the end of World War I. Since they could not identify it, they fortunately did not discard the culture but preserved it at the Pasteur Institute.

Twenty years later, Patterson, who was working in Cambridge on the first valid bacteriologic typing scheme of the Listeria organisms, identified the French strain as Listeria monocytogenes.

In the United States, Murray, Webb, and Swann[3] first described and identified Listeria monocytogenes as the cause of an epizoötic in rabbits in 1926. It was described under the name of Bacterium monocytogenes in view of the mononuclear leucocytosis which occurred in these animals. Pirie created the generic name Listerella for an identical organism obtained from an epizoötic in wild rodents. This proved to be a homonym and subsequently the name Listeria was proposed (Pirie, 1940).[4]

Family: Corynebacteriaceae (Lehman and Newmann)
Genus: Listeria (Pirie)
Type Species: Listeria monocytogenes (Murray, etc.), Pirie
Serotypes: 1, 3, 4a, 4b (Murray)

Serotype 4b is the most prevalent type in the U.S. (King and Seeliger).[5]

Listeria monocytogenes is a small, Gram-positive, straight or curved rod, 0.4-0.5 μ by 0.2-2 μ, with rounded ends, noncapsulated and nonsporeforming. It is motile at room temperature, showing peritrichous flagella at 20°C incubation. Nonflagellated mutants develop and occasionally mutate back to flagellated motile forms. It is anaerobic and facultatively aerobic, and grows best at 37°C on media enriched by liver extract or blood. Both smooth and rough forms are described on culture.

Patterson[6] studied 54 strains isolated from various animals and from man and found four types with three H antigens and three O antigens.

Robbins and Griffin[7] have designated the O somatic antigens as I, II, III, IV, and V and the flagellar H antigens as a, b, c, d.

Cross agglutinations occur as a result of common H antigens. There is no rotation between antigenic types, host specificity or geographical distribution.

Only 75 per cent of cases develop in their serums the Paul-Bunnell type of heterophile antibody which agglutinates the normal red cells of sheep. About 35 per cent have agglutinations to Listeria monocytogenes in addition to the agglutinins for sheep cells.

The Anton test, which gives a reaction in the conjunctiva of rabbits when live cultures are instilled, is a means of identifying Listeria from morphologically similar organisms like Erysipelothrix and motile phytopathogenic cornyebacteria.

Other more modern laboratory procedures like the antigen-fixation test for serodiagnosis, and the fluorescent antibody technic, are now being utilized in its identification.

Listeria monocytogenes has been confused with diphtheroids, streptococci, pneumococci, Hemophilus influenzae, Escherichia coli. For this reason, several authors have suggested that cultures of Listeria are often discarded without their true nature being suspected. "If this is true, there should be a relatively large group of either subclinical or mild inapparent infection with this organism." (Baker[8]).

The occurrence of such latent infections was also suggested by Osebold and Sawyer[9] who found agglutinating antibodies to Listeria monocytogenes in the sera of 77 of 468 veterinarians.

It might be that a screening test comparable to the skin tests used in tuberculosis and fungal diseases could be developed.

There is a Listeria Center of Western Europe, of which Doctor H. P. R. Seeliger[10] is the director. They have tested more than 250 strains in their laboratory in the last three years.

INCIDENCE

Only a comparatively few cases have been reported in the literature, when we consider how thoroughly the organism has been studied. This was commented upon by Seeliger[11] in his paper presented at the Communicable Disease Center in Atlanta, Georgia, in 1955.

A total of less than 600 cases have been reported in the literature to date. From 1891 to 1917, 56 probable cases were reported; 1918-1939, there were 29 cases reported; 1940-1949, there

were 40 cases reported; 1950-1955, there were 298 cases reported; 1957-1963 (April) there were 104 cases reported. Seeliger[12] in 1958 figured the total at approximately 500 cases.

Within the last five years, cases have been recorded as coming from all corners of the world, with increasing numbers of papers being published, notably in the United States, Germany, France, Russia, Great Britain, and Sweden. Contributions from Holland, Poland, Italy, Japan, Czechoslovakia, Norway, Denmark, Scandinavia, Spain, Israeli, Portugal, Finland, Scotland, Canada, Hungary, and Mexico are also adding to our knowledge of this subject.

EPIDEMIOLOGY

Many authors have commented on the "puzzling aspect of the epidemiology of listeriosis." Others have referred to it as an "opportunist."

So-called spontaneous infections have been found in more than thirty species of animals (Gray, 1958[13]) among which were cattle, sheep, pigs, cats, dogs, rodents, birds (canary), rabbits, guinea pigs, gerbilles [desert voles—Ed.], foxes, goats, and chickens (Beck[14]).

The organisms can be isolated from soil, silage, unpasteurized milk, and sewage.

The possible epidemiology of listeriosis could be explained by the presence of a biologic reservoir involving originally wild fauna which secondarily can infest domestic animals through transmission and which in turn can infect humans by environmental contact, and thus produce the clinical manifestations seen in all parts of the world.

SYMPTOMATOLOGY

In humans, Listeria monocytogenes produces varied and bizarre forms of infection. In the main, it can be diagnosed in (1) an infectious mononucleosis–like syndrome, (2) a meningitis or encephalitis, more often a meningoencephalitis, or (3) a septicemia resembling typhoid fever or an adenoid form like glandular fever or benign lymphoblastosis. A granulomatous sepsis involving the premature and newborn, sometimes labeled an oculoglandular infection or granulomatosis infantiseptica, is very fatal, often resulting in spontaneous abortions and neonatal mortality. Bacterial endocarditis, conjunctivitis, skin lesions, and residual psychosis have been implicated. It has been mentioned as a complication of steroid therapy, too.

A form of chronic listeriosis is also recognized. A quiescent, inapparent, or subclinical type can be revealed with agglutination tests.

Involvement of the CNS is the second most frequent manifestation, involving about a third of the entire group.

Over-all mortality rate in listeriosis is about 70 per cent without specific therapy.

DIFFERENTIAL DIAGNOSIS

Listeriosis resembles infectious mononucleosis very closely. Tuberculous or cryptococcous meningitis must be excluded. About 40 per cent of blood cultures are positive for Listeria monocytogenes (Claypool[15]).

TREATMENT

Sulfonamides are of no value. Penicillin has frequently been used. Sensitivity tests show that Aureomycin, Terramycin, chloramphenicol, and streptomycin could be used, in that order (Fink and Norman). Of course, the new antibiotics may turn out to be more effective.

Unfortunately, at the present time, there is no efficient immunization against listeriosis in man.

CONCLUSION

A case of listeriosis occurring in 1948 in a plantation community in Hawaii is reported. This is the only Hawaiian case recorded so far, according to the Department of Health records.

A discussion of the history, incidence, epidemiology, symptomatology, differential diagnosis, and treatment of the disease, listeriosis, together with the characteristics of Listeria monocytogenes, the infective organism, are here presented.

Listeriosis should not be a rare disease, were we to bear it more in mind. ■

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About one closed oviduct in five can be successfully recanalized.

Tuboplasty Evaluation

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• *Recanalization of closed Fallopian tubes can best be effected by end-to-end anastomosis over a polyethylene tube and cornual implantation into the uterus. The recanalization procedure is especially effective in the case of tubes severed surgically for sterilization.*

THE SURGICAL treatment of tubal occlusion has intrigued gynecologists for many years. Rubin's[8] great contribution, the insufflation test, revealed that approximately 40 per cent of 86,000 cases of sterility in women were due to closed tubes. Probably 30 to 35 per cent of all sterility problems involve some tubal factor.

Tubal operations for the correction of occlusion found no great favor with our generation of gynecologists. Greenhill's[3] report in 1937 of 818 cases with only 54 pregnancies, or one pregnancy in 15 operations, and with one live baby in 23 operations, was followed by the wide realization that newer approaches were required. Thus our study on the Rhesus monkey was undertaken in 1947. The earlier poor results with tubal surgery were mainly due to injudicious selectivity, poor patient material, improper splinting material, and inadequate diagnostic criteria.

The work of Hellman,[5] Rock and Mulligan,[7] Castallo and Wainer,[2] and others, on the use of polyethylene tubing and hoods in tuboplasty, afforded a new approach to this type of surgery. In 1956, Greenhill[4] resurveyed and collected the results in over 2,000 cases. In this group, one pregnancy occurred out of five operations. At about the same time, Siegler and Hellman[9] collected reports of 2,285 tuboplastic operations that had resulted in 378 live births out of 513 pregnancies. Their report revealed a pregnancy rate of 22 per cent and a live birth rate of 16.5 per cent.

PREGNANCY RATE STABLE

Many more operations are being done today than 20 years ago, yet the pregnancy rate remains at about 20 per cent, and the tubal patency rate

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Read before the Honolulu Obstetrical and Gynecological Society, March 12, 1962. Received for publication March 13, 1963.

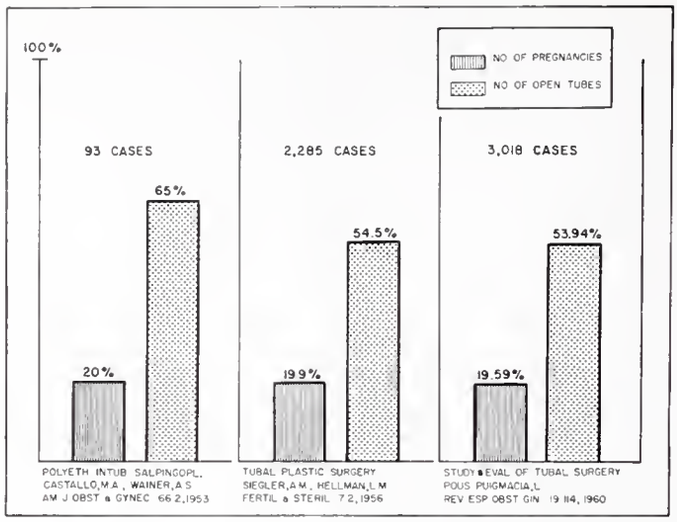


FIG. 1

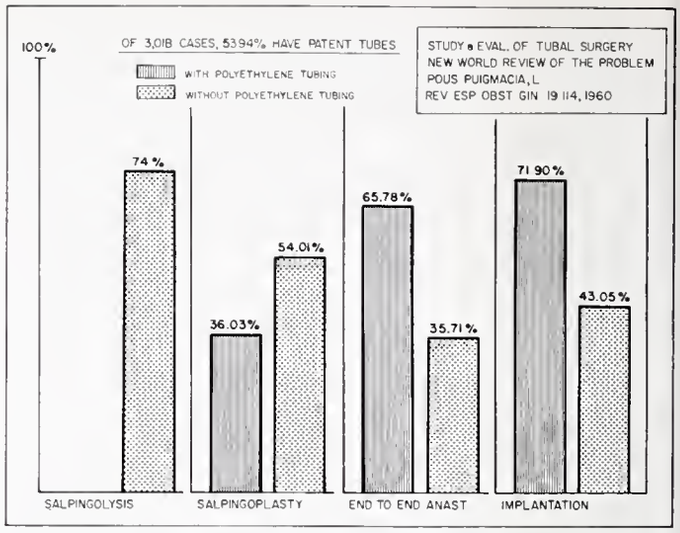


FIG. 2

at approximately 50 per cent. Tubal patency alone, even in women with normal tubes, does not necessarily make pregnancy possible.

In our first-reported series of 93 cases, in 1953, there was a 20 per cent pregnancy rate and a 65 per cent patency rate; while in 2,285 cases reported in 1956 by Siegler and Hellman,[9] a pregnancy rate of 20 per cent occurred and a patency rate of 55 per cent was reported. In the latest series of 3,018 cases collected by Pous Puigmacia,[6] 20 per cent pregnancies and 54 per cent patency were reported. While the American authors quoted presented cases of tuboplasty with polyethylene alone, Pous Puigmacia's reported patency of tubes included cases in which polyethylene tubing was not used, as recorded in Figure 2.

A summary of Puigmacia's findings is presented as follows: In salpingolysis, no polyethylene was used, and 74 per cent of the tubes were patent. In salpingoplasty, patency occurred in 54 per cent without polyethylene, and 36 per cent with polyethylene. In end-to-end anastomosis, the results are directly opposite: 66 per cent of patency was obtained with polyethylene tubing, and only 36 per cent without. In tubal implantation, 72 per cent were patent with polyethylene, while 43 per cent without. It is evident that in end-to-end anastomosis and tubal implantation, the results are much better with the use of polyethylene.

SELECTION OF PATIENTS

In the surgical management of tubal occlusion, no one factor is more important than the careful selection of patients for operations. A complete evaluation of both partners is essential, and should be conducted as outlined in the booklet on the criteria for evaluation of sterility, published by the American Society for the Study of Sterility. Both husband and wife are required to be studied before any operation is considered. A careful history of the woman involved is most essential; evaluation of any previous surgical procedure is of utmost importance. It is essential that all of the diagnostic procedures for the evaluation of any sterile couple be carried out in each patient considered for tuboplasty, even though the occlusion be the result of a previous surgical tubal sterilization. The husband should be completely evaluated as to general physical condition, sperm count, and any abnormality of his genital tract.

The woman's survey must include basal body temperature graphs, endometrial biopsy, and ferning smears for proof of ovulation, following a complete physical examination. BMR and preferably a PBI for estimating thyroid function should also be included. Repeated Rubin tests are of importance for showing tubal nonpatency; however, the problem of tubal spasms, apt to occur in hyperkinetic women, should be considered, and repeated Rubin tests, with the use of tranquilization, are also recommended.

Hysterosalpingography is probably the most important individual aid in the diagnosis of tubal occlusion. We prefer the use of oil-soluble media, fluoroscopy with stereoscopic films taken at the time, and a 24-hour follow-up film. We follow four negative Rubin tests, after each of four periods, with this x-ray study. In the event that a hysterosalpingogram is questionable, it should be done under anesthesia to rule out tubal spasm. A hysterosalpingogram shows the location of the obstruction, whether bilateral or unilateral. It also delineates uterine abnormalities. Both the Rubin test and x-ray studies should be done several times in tubal occlusion, for many patients become pregnant after repeated Rubin tests, and pregnancies do occur after hysterosalpingography.

Weir and Weir[11] found that in a study of 32 infertile couples, five (15 per cent) conceived after

sex education alone, 15 (50 per cent) conceived after hysterosalpingography, and 12 (25 per cent) remained infertile. Snaith,[10] in a study of 1,524 sterility couples, reported that 13 per cent conceived without any treatment whatsoever. All of us who do gynecology have had the same experience. But the couple that stays infertile, after many months of treatment, is the problem which taxes our ingenuity. Surgery for tubal occlusion is reserved, therefore, for the very few infertile women who have proven tubal pathology not amenable to the usual methods for cure, and a husband who is fertile.

FACTORS AFFECTING RESULTS

The gynecologist who does the first fallopian tube surgery has the best chance of success. His experience and skill in tubal surgery are of the utmost importance. Success of subsequent operations on the fallopian tubes is much less likely. It is, therefore, important and in the best interest of the patient to consider as the surgeon of choice the best trained man in tubal plastic work in the area. The more such operations he has done and the more delicately he handles tissues, the greater his success. The more normal the tubal tissues at operation, the better the results. Therefore, the determination of the cause of sterility prior to operation is extremely important. One can tentatively predict the degree of success according to the cause of sterility.

The most frequent cause of tubal occlusion is pelvic inflammatory disease, with its resulting salpingitis that produces tubal adhesions, fimbrioclosure with hydrosalpinx, tubo-ovarian abscesses, and pelvic peritonitis. However, peritubular adhesions and hydrosalpinx are the most common operative findings. The greatest destruction of tissue occurs, of course, with hydrosalpinx and fimbrioclosure. Hydrosalpinx produces the most extensive tubal damage.

When the tube is extremely clubbed, the fimbriated end is unrecognizable, the mucosa is completely thinned out, and the muscularis is practically nonexistent in many cases. However, even though patency can be achieved with conservative operation by means of polyethylene splints or hoods, it has been shown in Figures 1 and 2 that about one-third of these tubes function normally in producing the pregnancy.

Perisalpingitis with peritubular adhesions, does not result in a great deal of destruction of the mucosa of the tube, as shown in Figure 2, and therefore yields better surgical results. Other positive etiologic factors in tubal occlusion are postabortal endometritis, postpartum endometritis, and endometriosis. Still another cause of tubal occlusion is tuberculous salpingitis, a condition not frequently found in patients in the United States.

Occlusions due to previous sterilization procedures cannot be disregarded, as they are distinct conditions causing sterility, and are most amenable to good results, since the tube was normal when severed. Some recanalize spontaneously, much to the embarrassment of the surgeon and the patient.

If the tubal factor can be determined prior to operation to be merely peritubular adhesions, better results than with any other type of inflammatory reaction in the pelvis may be expected. However, the presence of such adhesions is almost impossible to establish prior to surgery.

Endometriosis involving both the tubes and the ovary is difficult to evaluate at the time of operation, because careful consideration must be given to the conservation of ovarian function. At the same time, the proximity of the tube to the ovary is essential for proper migration of the ovum. Many times it is difficult to conserve tube and ovary because of an extreme endometriosis found at operation. Despite the fact that only four per cent of infertile women have endometriosis, conservation is extremely important, because many of these patients will become pregnant after conservative surgical management. We have had several in our practice, within the past few years, who have conceived after suppressive therapy of from three to six months.

TECHNIQUES OF TUBOPLASTY

We are of the opinion that all patients should be treated preoperatively with a course of antibiotics, to prevent postoperative reaction from old pelvic inflammatory disease. Surgical technique itself is of extreme importance. Sharp dissection, gentle handling of tissues, complete and careful hemostasis, and the use of delicate instruments, such as those used in ophthalmic and neurological surgery are recommended. To avoid the destruction of tissue with large instruments, only the finest eye probes are employed. Atraumatic needles with five-0 or six-0 catgut are used for suture material. Polyethylene tubing that has been sterilized electronically and animal-tested, affording little chance of tissue or chemical reaction from the sterilizing material, should be used.

Since the greatest chance of success comes with the first operation, it is essential that, after the abdomen is entered, complete appraisal be made of both tubes and ovaries before any reparative work is attempted. Before any tubal plastic operation is considered, all other means of opening the tubes should have been attempted, including several Rubin tests and hysterosalpingographies as outlined above. The laparotomy should be preceded

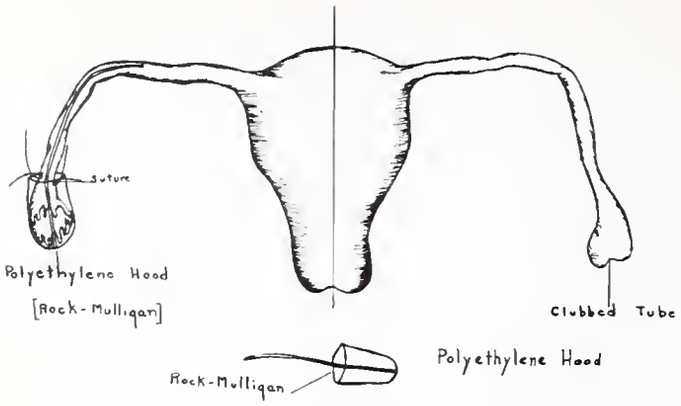


FIG. 3.—*Occlusion at the fimbriated end. After the ostium has been opened, the umbrella-like splint of polyethylene is sewed to the fimbriated end. This mold is left in place for a period of eight weeks, being then removed by a second abdominal operation. (Castallo, M. A., and Wainer, A. S., Am. J. Obst. & Gynec. 66:385, 1953. Courtesy of the publisher.)*

by dilatation of the eervix, and injection of methylene blue in order to demarcate the area of excision of the tubes.

The proper use of splint material, particularly polyethylene tubing, increases the number of good operative results in certain circumstances, as shown in Figure 2. It should always be used in midtubal and end-to-end anastomosis, and in cornuplasty, and should be considered for salpingoplasty and salpingolysis wherever there has been trauma to the tissue or where tubal patency is threatened because of postoperative edema.

The techniques of using splinting materials, particularly polyethylene, in all types of tubal operations are as variable as the surgeons. Our methods of dealing with the three main types of tubal occlusion are shown in Figures 3, 4, and 5.

Many methods have been used to bring the tubing out to the abdominal cavity. The distal, free end has been brought out through either the abdominal ineision, or a lateral abdominal stab wound, or sutured under the skin. When polyethylene tubing has been used in fimbrioplasty, its removal has been accomplished by bringing it down through the uterine cavity by perforating the uterus and threading it through the uterine cavity and into the cervix, where it is sutured to the cervix with silk sutures. The uterus has been widely opened and the loop placed through both fimbriated ends and tied to the cervix, and has been brought out through the cul-de-sac and sutured to the vagina.

There is no routine manner of using polyethylene tubing or removing it. In several instances we have allowed the tubing to remain in the peritoneal cavity, giving the patient a written copy of the procedure.

Great care must be exercised that the mesosalpinx is not compromised when the tube is brought into the uterine cavity during cornual implantation. The tube should be fish-mouthed prior to implantation. The cornual borer is not recommended. The cornua of the tubes should be widely excised by scissors so that implantation may be accomplished with a minimum of trauma and with little or no postoperative pressure upon the tube (Figure 5). Whenever polyethylene tubing is used, antibiotic therapy should be administered throughout the ten days of the postoperative period. Corticosteroid therapy should be considered when there is a great deal of operative reaction.

The surgeon who knows the exact procedure he intends to follow, and who persists in following it, is not suffieiently flexible to do this type of work. The extent of the operation to be performed, as well as the particular type for eaeh case, is dictated by the condition of the pelvic organs at the time of operation. Each surgeon must improvise for the individual case during surgery.

It is essential that the entire procedure plan, the operative morbidity, and the possible percentage of cure be discussed with both husband and wife prior to tuboplasty. The potential of success should be explained in definite figures, because the woman is being subjected to possible morbidity and mortality, albeit low. Nevertheless, it will be stated by many a couple, that, after all, they have no chance as they are, every other type of therapy having been tried, and with about a 20 per cent chance of pregnancy with tuboplasty, it is worth their risking an operative procedure. We leave this decision up to the patient.

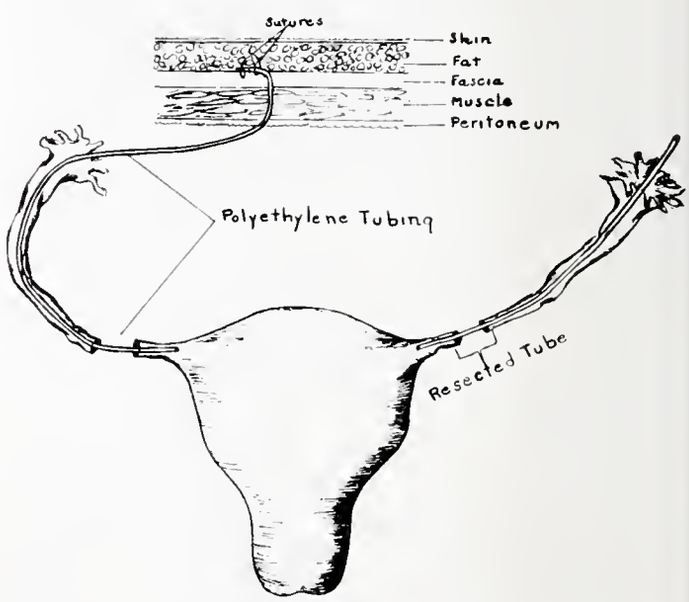


FIG. 4.—*Mid-tubal obstruction. Polyethylene tubing is placed in the gap created by excision of the occluded portion, and the tube allowed to grow together over this splint. No attempt is made to suture the incised ends. A long loop of tubing is allowed to remain free, sewed to the anterior sheath of the abdominal fascia, and subsequently removed under local anesthesia in eight weeks. (Castallo, M. A., and Wainer, A. S., Am. J. Obst. & Gynec. 66:385, 1953. Courtesy of the publisher.)*

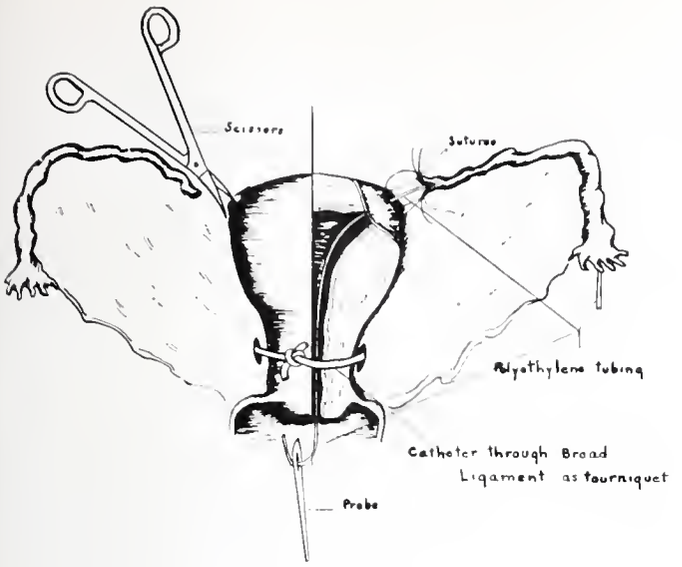


FIG. 5.—*Cornual blockage. To minimize bleeding, a tourniquet is placed around the uterine vessels and rubber-covered Williams intestinal clamps (not shown) placed on the ovarian vessels. The tube is excised from the cornu and its free end fashioned into a "fish mouth." Scissors are employed to freshen the new cornual opening. The correct size of polyethylene tubing, threaded with stainless steel wire, is passed through the tube and attached to a surgical probe, which carries the prosthesis into the new opening and through the uterine cavity. The "fish mouth" end of the tube is sewed in place with fine catgut sutures. The polyethylene tube is sutured to the cervix with silk and removed eight weeks later. (Castallo, M. A., and Wainer, A. S., Am. J. Obst. & Gynec. Courtesy of the publisher.)*

When prior surgery has been done, or we expeet serious pelvic disease, written consent to do any type of uterine or tubo-ovarian surgery, ineluding hystereetomy, is obtained.

SUMMARY

Careful evaluation and seleetion of patients, as well as a eonservative surgical approach, are the rules in tuboplasty. The use of polyethylene tubing as a splint results in greater frequency of tubal pateney, in end-to-end anastomosis and eornual implantation. However, pregnaney does not always follow, even where there is pateney, espeeially when there is badly damaged tubal musculature and apparent failure of regeneration of tubal mueosa. Complications are few after tubal plastic operations, if extreme care is exereised in the handling of tissues and in their repair. The ineidence of eetopic pregnaneies is, in most series, about ten per eent, and if abortions are included, pregnancy wastage inereases to 15 or 20 per cent, which is elose to the normal rate to be found in pregnaney.

Tuboplasty proeedures should be earried out by the gyneeologist who is espeeially interested and trained for this type of surgery. The over-all pregnaney rate in over 5,000 operations reported in the literature, is about 20 per eent, with higher rates in selected eases, such as reeanalization of surgieally severed tube to produce sterility. ■

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The President's Page

Hearings on the King-Anderson bill were completed on February 10, and so again the legislative wheels have begun grinding, and sometime during the latter part of March the Ways & Means Committee of the House will vote on whether this bill, or a reasonable facsimile of it, should come out of committee and on to the floor of the House. So again, as in several previous years, the people of the U.S.A. are being threatened with the greatest hoax ever perpetrated on our unbelievably unsuspecting people.

The proponents of the King-Anderson bill have shown over and over again that they are not concerned with the truth. They seem only to be concerned with further enslaving the American public and increasing our dependence on the constantly growing giant of power and manipulation centered in Washington, D. C. Right now they have the unabashed gall to ask that millions of wage earners give up most of their savings from the recent tax cut and place this money in a "fund" so that the hospital and nursing home bills of over a half million elderly persons with an annual income over $10,000, and of another 10 million who already have hospital insurance, can be paid by the Federal government through the Social Security mechanism.

Even our President in his health message intimated that these moneys—obtained through payroll taxes—would be set aside for the worker to pay for his medical care in his old age. Certainly, he must know that nothing—yes, absolutely nothing—will be set aside for the future needs of these workers. Every penny obtained, in what almost amounts to a fraudulent manner, plus more money from other taxes, will be needed to pay hospital bills for people already 65, including the wealthy. At no time would there be a "fund," and at no time would the wage earner be assured that when he reaches 65 there will be money available in such a "fund" to pay for his hospital bills.

It is estimated that if the King-Anderson bill passes, it would immediately impose an unbelievable liability of $35 billion on OAIS (social security) in order to cover the expected lifetime hospital expenditures of those who would be eligible for care at once—those people who will never have contributed a dime to the program! This money would have to come from the contributions of younger workers who would be paying their family medical expenses out of their own pockets while they pay taxes for these elderly, millions of whom are completely solvent and able to handle their own needs.

This bill is also being pushed at a time when the number of aging requiring public assistance is declining (from 23% in 1950 to about 12% in 1963). This is due to the increasing numbers of 65-year-old newcomers who have lifetime pensions, savings accounts, home ownership, liquid assets, tax credits, health insurance coverage, and other protective devices against financial catastrophe which are raising their economic level so that they are well able to care for themselves.

With the above facts, and many others not stated, one cannot help but realize that the pressure for Federal assumption of the health care costs of 17,500,000 older persons does not derive from their economic status—obviously the pressure must be political! For this reason the administration has always taken strong exception to organized medicine's effort to bring before the people its side of the Federal medical care controversy. I feel that this is not only medicine's right, but medicine's obligation, to guard the quality of medical care in this country and to prevent the standards of medical practice from being corrupted and interfered with by a government bureaucracy. Therefore since we all have an obligation to our patients, what are you and you going to do about it? I don't know what you are planning to do about it, but this is what you *should* do:

First, let your Washington representatives (Tom Gill and Spark Matsunaga) and senators (Hiram Fong and Dan Inouye) know how you stand, and then get your friends who think as you do to do likewise. Maybe we won't change the closed minds of some of our Washington legislators, but this is the only way of telling them that their constituents do not want any type of medical care for the aged tied up with Social Security—and maybe they will get the idea.

Second, do not in any way support those national candidates who favor the King-Anderson type legislation, and do your best to see that they are defeated at the next election. As I have said before, do not let your pride in being social friends or old classmates of these men who would "sell us down the river" blind your reasoning and good sense. They will not hesitate to vote for this legislation which we know will be the "foot in the door" for federally regulated medicine, and they will be the first to gloat over the patronage afforded them by helping to appoint the bureaucrats who will sit in judgment of and control your practice of medicine. Why are so many of us so unable to see the light and the true "politically expedient" colors of these men?

Third, become better informed and work actively to explain to our patients and groups of citizens the facts of the so-called hospital insurance hoax, Fedicare for all the aging. Get behind speakers groups, and others who are giving of their time, energy, and money to save the freedom of the practice of medicine—yours and mine.

Fourth, let's do all of this before it is too late.

Rodney T. West M.D.

HAWAII MEDICAL JOURNAL

Editorials

Hawaii Cardiovascular Study

A research project in cardiovascular diseases, now going on in Honolulu, bids fair to reveal some worthwhile and perhaps previously undefined aspects of the problem. This is David Bassett's Hawaii Cardiovascular Study, housed in The Queen's Hospital. This project was launched by Joe Stokes during his tenure in Honolulu, before he moved to LaJolla to become dean of the new medical school there.

Dr. Bassett is earnestly and urgently asking practicing physicians to bring to his attention men of Japanese and Hawaiian ancestry, ages 35 to 65, who have survived a heart attack.

Encouraging participation of patients and controls, who have already been contacted by the HCVS team, is another way in which Honolulu physicians can assist this research program.

Lactescence of fasting serum (hyperglyceridemia or hyperlipemia) has been noted in a few cases, and Dr. Bassett is hoping to determine the etiology of such conditions. If you have a Japanese or Hawaiian patient with serum cholesterol of greater than 350 mg %, he (or she) would qualify for this phase of the study.

In every instance, a report will be sent to the subject's private physician upon completion of laboratory tests. This is an opportunity for impecunious patients to have a complete cardiac survey at no cost to them, since the lab tests are provided through a grant of the National Heart Institute.

The project is jointly supported by the Heart Institute, U. S. Public Health Service, Hawaii Heart Association, and Hawaii State Health Department, and has the approval of the Honolulu County Medical Society Board of Governors.

Phone Dave Bassett at 504-667 for information on the study or to alert him to a prospect for his study group.

HAMPAC

The penalty good men pay for indifference to public affairs is to be ruled by evil men.

—PLATO

Congratulations and thanks are in order to ten Hawaii physicians—and one physician's wife—who are *not* indifferent to public affairs: Drs. John Carson, John Chalmers, Patrick Cockett, Maurice DeHarne, George Goto, Chisato Hayashi, Howard Liljestrand, James Matayoshi, "Jiggs" McArthur, Allen Richardson, and Mrs. Donald Jones. They are the members of the Board of Directors of HAMPAC, Hawaii's chapter of the national organization, AMPAC. Chairman is Howard Liljestrand; Vice Chairman, John Chalmers; Secretary-Treasurer, George Goto.

Promotion of the active interest of physicians as a group and as individuals in the political affairs of Hawaii and the nation is the avowed purpose of this organization. It is nonpartisan and deserves our unanimous support, with both money and political activity. If you haven't contributed to it yet, now is a good time to correct the omission with a check. Dr. Goto will be happy to receive it.

HAWAII MEDICAL JOURNAL

Bureau of Medical Economics

This Money Business

How many of you, having time to watch the "Ben Casey" or "Dr. Kildare" T.V. programs, have envied these "shadow medics"? Everything in order: assistants who do the right thing at the precise moment that it is required, and never once the sordid mention of money.

This money question is one that most of us would sweep under the rug were it possible. However, a doctor has to meet his commitments like every other business man and, therefore, must protect his financial affairs. This brings us to the point of delinquent accounts, and how best to avoid them. As stated in the last issue, there will always be delinquent accounts, but much can be done to (a) collect through the endeavors of your own staff, and (b) avoid giving them to a collection agency, thereby saving yourself from paying up to 50 per cent in collection fees.

Your first line of defense is your assistant, or the person who interviews the prospective patient in the first instance. Granted, she has to be kind and considerate, but she should be firm in her approach. She must insist on complete information pertaining to the patient. The patient information form she fills out should be clear and concise. We suggest the type supplied by the Bureau of Medical Economics. It should carry the name of the patient's spouse; nearest relative's name and address; spouse's place of employment (if employed); name of insurance company (if any), as well as policy number. All these facts are invaluable in tracing a delinquent.

At the bottom of the form, the following wording should appear:

> "In the event that a delinquent account is placed in the hands of a collection agency or an attorney for collection, or suit is instituted on this account, I (we) agree to pay, in addition to the amount of the delinquent account and interest, a collector's or attorney's fee equal to 25% of the said delinquent account."

This is the physician's safeguard in the event that the account is handed over to a collection agency. The added 25% helps pay the collection costs. This is fair, as the onus of collection costs should be on the debtor.

Such forms can be obtained from the Bureau of Medical Economics offices for 15¢ for a pack of 50.

If the patient is a habitual delinquent, he usually gives a large cannery or construction company, etc., as his employer. This can be an evasive method of withholding the true place of employment, as such information is usually accepted. In such cases your assistant should insist upon more specific information. Pinpoint the department, and, if possible, the immediate foreman. Information is the keystone of the collection business, and should be as well in the doctor's office. You, as administrators of hospitals and clinics or as doctors, are really in the minority as far as total financial contact with your patients is concerned. It is in your interest to see that your assistant is properly alert and trained to handle the ever present contingency of the delinquent.

You are in a health industry, and as such you should help protect that industry by protecting your own interests. There is nothing unethical in asking for the money that you have worked for and earned; this is your right and prerogative. We the Bureau of Medical Economics can give many pointers to your assistants. Have them call us, to ask our advice on matters pertaining to collection. We are here to help—help you collect your own accounts. We only want your accounts after your office has gone as far as possible. By this, I don't mean just sending out monthly statements, and then hoping. Personal contact with the debtor is essential. This is why one of the first rules of a good collector is *"Always get a phone number."* If the patient has no phone, there is always a neighbor who has one. Nobody will object to giving a doctor's office full information. It is all a matter of the way the questions are asked.

One final point: when your assistant has tried to collect and failed, teach her to pass the account on to the collectors. It is not of use to let it languish in your files; this will not bring in the money. Have her send all the pertinent information to the collectors, including the agreement of the 25% addition for collection. This document is of no use to you once you have assigned the account.

See to it that you help yourself, by helping the collector, by giving all the information which should be in your possession if your help is doing her job in the proper manner. ■

GABRIEL ROGERS
Manager

Hawaii Academy of General Practice

CHILDREN'S HOSPITAL

For a city of not much over 350,000 population, Honolulu is unusually fortunate in having a specialized medical center in Kauikeolani Children's Hospital. It is all the more unusual for the fact that this city does not have a medical school with all its attendant facilities, consisting primarily of teaching beds and a faculty.

The Children's Hospital might be just another hospital, and may yet deteriorate into being one (if it does not actually come under the auctioneer's hammer), were it not for its two-year accredited residency in pediatrics. What makes of it a medical center is that residency training program. The existence of a children's hospital and medical center is synonymous with its accredited residency training program. It is right and proper that the two be housed in a special facility such as Kauikeolani.

LOSS OF IDENTITY FEARED

If Kauikeolani were to be merged with Queen's, its identity would inevitably be lost, and, consequently the concepts of a children's medical center with its attendant specialized residency training program would be absorbed by and into the broader program and would disappear.

Many might say: "Well, what of it? Queen's program would be better because it would be aggrandized. All we really want is a place for our patients to get proper nursing services, laboratory and x-ray services, efficient operating rooms, and enough house staff to take care of the routines."

A few physicians in this community are additionally imbued with the ideal of teaching, and do offer their services in the hospitals to that end.

Some of us have a strong feeling for the inherent worth of a topnotch teaching institution, be it a full medical school, a baccalaureate in basic medical sciences, or a full and accredited residency training program with a dynamic Director of Medical Education in charge. Is there any good reason why we doctors shouldn't rally around to support and build up the one we already have at Kauikeolani and make it better and better? Surely we can see the worth of such a thing for the children of our community—our patients who have the most to live for. Surely we can see the value of having a place to which to send our sick pediatric patients, both physicians and parents secure in the knowledge that these patients will be under the capable hands of topnotch pediatric resident physicians, well trained and well supervised. Surely we physicians can see the value of such a center, to which we can continue to go to school to receive continuing postgraduate education!

Kauikeolani's liabilities number just two—major ones, that is: a low census and a large monthly financial deficit. The two go hand in hand, of course, but that also makes it the easier to remedy. Boosting the census will help remedy the deficit directly. Indirectly, the response to physician support will be manifest by geometric progression. The trustees will be surprised and pleased; they may be much more likely to go along with requests for additional funds for the continuing education program. This will give the residency training program a shot in the arm; more and better qualified men and women will apply. Special programs and clinics can be better staffed, which, in turn, will attract research projects and grants, university affiliation, etc. The upward spiral of success will begin.

WHERE DOES THE GP FIT IN?

The GP has not had a happy relationship with Kauikeolani. It has been the home ground of the pediatricians and the Pediatric Society. Although the GP's, together with the surgeons and the otolaryngologists, have been invited to participate in the departments of the hospital, on its committees, and on the executive committee, they are excluded from officership. The pediatric resident tends to have no respect for a GP, and, being generally young and brash, he either shows or is thought to show his mild contempt. No studied effort has been made by the pediatricians to include GP's on teaching rounds, panel discussions, etc. Perhaps the ultimate in detrimental adiplomacy was the diatribe in the newspapers blaming the collapse at Kauikeolani on the GP's.

Nevertheless, if Kauikeolani goes under, it will be our loss—the GP's'. We are not the type to be teachers; we are the learners, the listeners. It is to our own selfish interest to preserve and build up an institution from whose teachers we can forever benefit. Much as we would like to see a little more understanding and "meeting-you-halfway" attitude on the part of the pediatricians, we should put resentment aside and do all we can to assist Kauikeolani to get on its feet and stride forward. It is our patients who will benefit, and we take care of more kids than the pediatricians do! ■

J. I. FREDERICK REPPUN, M.D.
Secretary

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii

This is the forty-eighth installment of In Memoriam—Doctors of Hawaii.

Richard Gilbert Ayer

Richard Gilbert Ayer was born in Haverhill, Essex County, Massachusetts, on December 27, 1867. He was the son of Richard Gilbert and Katherine (Hall) Ayer. His father was a shoe manufacturer in Haverhill.



DR. AYER

Young Richard's elementary education was received in the private schools of Haverhill, Tilton Academy, Tilton, New Hampshire, and at Phillips Andover, Andover, Massachusetts. He attended Harvard University and graduated from Harvard Medical School in 1891.

Dr. Ayer began his professional career in the Massachusetts General Hospital at Cambridge.

On September 15, 1896, he married Blanche Estelle Westcott at Albany, New York. The Ayers had one daughter, Mildred Florence.

Dr. Ayer spent 14 years in private and hospital practice in the Mexican states of Durango, Chihuahua, and Zacatecas. Revolution and a change of government broke up his practice and he and Mrs. Ayer fled for their lives across the border.

Coming to Honolulu, Dr. Ayer entered private practice in February, 1914. In 1915 he gave up his practice when he was appointed police surgeon and physician at Emergency Hospital and physician for the Rapid Transit Company. His interest in the Emergency Hospital was responsible for its growth from a makeshift affair of limited medical and surgical facilities to an efficient and modern unit. He also advocated the segregation of criminals from other patients at the insane asylum.

Dr. Ayer died March 30, 1926, in Honolulu, at the age of 58.

He was a member of the Medical Society of Hawaii and of a number of college clubs.

Yoshihiro Sugamura

Yoshihiro Sugamura was born in 1883 in Imasato machi, Shirogane, Minatoku, Tokyo, Japan.

He was graduated from Kumamoto Medical School in 1906. In 1910 he received a degree from Tokyo Imperial University in the Ear, Nose and Throat department.

In 1913 he arrived in Hawaii and practiced in Wailuku, Maui. During that time he was very active in community affairs and was President of the Maui Education Association in 1917.

Between 1919 and 1921 Dr. Sugamura did postgraduate work in pathology at Izumibashi Hospital in Tokyo. He then went on to New York Medical University for further studies in surgery of the ear, nose, and throat.

After a year in New York, Dr. Sugamura returned to Hawaii and practiced in Hilo until 1928. In 1923 he was Vice President of the Hilo Japanese Community. From 1929 to 1940 he was Superintendent of Kona Hospital. He was Chairman of the Board of Directors of Kona Industrial Organization in 1930.

Dr. Sugamura was a devout Shintoist and a gifted writer and published several pamphlets on "Shintoism." In 1940 he received official recommendation from the foreign minister of Japan for his services among Japanese in Hawaii.

He died in 1945 in Tokyo, Japan.

Sanjiro Nakaba

Sanjiro Nakaba was born on July 1, 1882, in Miyaji, Tsuyasaki-cho, Munakata gun, Fukuoka Prefecture, Japan.

He received his medical degree from the Osaka Medical College in 1908.

On November 30, 1914, he came to Hawaii. He was passed by the Territorial Board of Medical Examiners and began his practice on North King Street in Honolulu.

Dr. Nakaba and his wife, Suwako, had four children; Toshiharu, Mizuo, Emiko, and Fumiko.

On October 25, 1933, Dr. Nakaba returned to Japan. He died on April 1, 1947, in the town where he was born. ■

HAWAII MEDICAL JOURNAL

This Is What's New!

• **Milk allergy** was found to begin in the first few months of life in 89 children having symptoms of milk allergy. Challenge with milk or milk protein produced vomiting, diarrhea, abdominal pain, asthma, rhinitis and atopic dermatitis. These symptoms appeared within 12 to 24 hours of oral milk challenges and occurred on challenge in 78 per cent of the patients. (*Pediatrics* [Sept.] 1963.)

• Diseases attributed to **chromosomal abnormalities** have continued to increase. The **E_1 trisomy,** or group 16 to 18 syndrome, is associated with multiple congenital anomalies. Ninety percent of cases reported have **congenital heart lesions,** which are often the cause of death. **Thyroglossal duct cysts, adrenal dysplasia, glomerulosclerosis,** and **microcysts of the kidneys** are now reported as well. (*Pediatrics* [Feb.] 1964.)

• The modern up-to-date hospital, with the most recent diagnostic procedures available, can be a rather hazardous place. Of 1,000-odd patients studied on the Yale University Medical Service, approximately **20 per cent** developed some **complication attributed not to the disease but to hospitalization.** These episodes consisted largely of reactions to **diagnostic procedures, drugs,** and **transfusions.** Of the drug reactions, half were due to **antimicrobial** or **hormone** preparations. Hospital acquired **infections,** especially with Staphylococcus aureus, Candida albicans, and so forth, contributed to the hospital hazards. Six of the patients studied **died** of hospital-acquired infections. The average hospital stay for patients developing a complication of hospitalization was over twice as long as the hospital stay of the patients who did not have such complications. (*Ann. Int. Med.* [Jan.] 1964.)

• **"Marboran"** may be the most significant advance in **smallpox control** since the day of Jenner. This thiosemicarbazone, an oral medication, appears to be far superior to smallpox vaccination after exposure to smallpox. The results are really remarkable. Of 1,000 contacts given Marboran, only three mild cases of smallpox occurred. In the control group of approximately 1,000 contacts, 78 cases of smallpox occurred, of which 12 were fatal. Both Marboran treated cases and the control group had similar smallpox vaccination histories and age distribution. This drug apparently protects the unvaccinated even when administered late in the incubation period. (*Lancet* [Sept.] 1963.)

• The antimalaria drug, **chloroquine,** is widely used in treatment of lupus erythematosus and rheumatoid arthritis. It also unfortunately causes **retinopathy** in many patients. **Early diagnosis** of this retinopathy is important because only the earliest lesions will **regress** if therapy is discontinued. In an attempt to arrive at early diagnosis, New York ophthalmologists resorted to electronic gadgets in the form of electro-oculograms and electroretinograms. Neither is diagnostic, but funduscopy revealed the earliest changes of chloroquine retinopathy, namely, **macular mottling,** in slightly more than **one-third** of 39 patients studied. (*Arch. Ophth.* [Feb.] 1964.)

• **Hyperbaric oxygen therapy** at two atmospheres pressure appeared to be responsible for the **survival** of a man with **coronary thrombosis** and severe **secondary shock.** At the time of this 56-year-old man's transfer to the high-pressure chamber, his blood pressure could not be recorded and he had failed to respond to routine methods of treatment, including oxygen tent, vasopressor drugs, and close nursing care. Two hours after he was put in the chamber his blood pressure had risen to 100/80, and he survived. (*Lancet* [Jan.] 1964.)

• Recent work in patients with **muscular dystrophy** indicates a **reduction in total body potassium** with a major alteration in the relationship of potassium to body water. Los Angeles investigators now report that nondystrophic **relatives** of patients with muscular dystrophy have a similar abnormality. The potassium distribution was studied by using radiopotassium 40. These studies strongly suggest a **genetic biochemical defect.** (*New Eng. J. Med.* [Jan.] 1964.)

• Severe **hypoglycemia** accompanying **acute alcoholism** is not too rare a syndrome and is easy to overlook. Eight such patients were seen at the Boston City Hospital over a two-year period. Various studies carried out on this small group of patients failed to precisely pinpoint the cause of the hypoglycemia. Depletion of hepatic reserves including lowering of the blood sugar followed alcohol intake and persisited after rehabilitation with adequate food intake. (*J. Clin. Invest.* [July] 1963.)

• Fatal progressing **wasting disease** has been produced in male hamsters by **thymectomy.** The wasting disease could be produced in female

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Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

January 29, 1964, at 6:00 p.m.
Oahu Country Club, Honolulu

PRESENT:

Dr. Rodney West, presiding; Drs. Allison, Andrews, Chinn, Giles, Lum, Miyamoto, Nishijima, Pinkerton, and Wade, plus guests—county society presidents Drs. Richardson, Fujii, and Fleming; Dr. Richard Moore, AMA Delegate; committee chairmen Drs. Chalmers, Legislative Committee, Mamiya, Medical Education, and Ivy, Public Relations; Mr. John Pompelli, AMA Field Representative; and Mr. Tom Thorson, Honolulu County Medical Society.

MINUTES:

The minutes of the November 20, 1963, meeting were approved as recorded.

COMMUNICATION REQUIRING ACTION:

A letter from the Dental Association relative to taxation of professional services.

ACTION:

It was voted to refer this to the Public Relations and Legislative Committees for their recommendation.

Request from Brain Research Foundation: It was noted that a request of this sort is usually left to the discretion of individual doctors. Mr. Pompelli was asked how other states handled this sort of thing. Mr. Pompelli advises that other states have a policy not to contribute to fund raising organizations from their state association treasury and doctors are asked to contribute individually. Mr. Pompelli said that AMA does have a department that investigates organizations asking for such requests. Dr. Chinn felt that some kind of ruling should be set up by the Council which would permit the executive secretary to handle such requests without approaching the Council each time one is received.

ACTION:

It was voted to establish a policy of referring all solicitations for funds to the AMA for investigation. No contributions will be made from the Association's treasury. However, if the AMA's report contains nothing derogatory, the solicitation will be publicized in the monthly Newsletter and individual physicians may contribute if they so desire.

Letter from Alexander & Baldwin: Mr. Pompelli was asked to give the Council an idea of what other societies do about group life insurance. Mr. Pompelli said that many societies feel this is a good thing. Mr. Pompelli stated that it is entirely up to the Association to make the decision.

ACTION:

It was voted to give Alexander and Baldwin the same consideration we gave to Northwestern Insurance Company, but that the Hawaii Medical Association does not give endorsement to their product.

Request from national association for the prevention of addiction to narcotics:

ACTION:

It was voted to handle this request the same as the one from the Brain Research Foundation.

REPORT OF THE SECRETARY:

The Secretary's report was reviewed as circulated.

ACTION:

It was voted to return the $22 for Legislative Assessment to Dr. Cecil Saunders.

It was voted that the request by Dr. E. Wonsik Yon be noted and denied.

It was voted to approve the Secretary's report.

REPORT OF THE TREASURER:

The Treasurer's report was reviewed as circulated.

The Physicians' Benevolent Fund was discussed. It was noted that money for this fund is obtained from new members and that each member of the HMA is billed for $10 each year for five years. It was also noted that less than 50 per cent of the membership have pledged to this fund. Dr. Chinn said if this fund can grow to a sizable amount, we may be able to help young doctors get started in their practice and help physicians in many other ways.

There was a discussion of the retirement plan for HMA employees. It was noted that the HCMS proposal includes all employees of the Association who are working at the time the plan goes into effect. A waiting period of one year will apply only to personnel employed after the plan goes into effect. The House of Delegates approved participation in the HCMS retirement plan but funds were not budgeted for new employees. Mr. Tom Thorson briefed the Council on the details of the plan and advised that it provides for participation by additional nonprofit organizations.

ACTION:

It was voted to include HMA employees in the Retirement Plan as set up by the HCMS, effective February, 1964.

The proposal that meals for employees required to attend meetings and guests invited to attend meetings be paid for was discussed.

ACTION:

It was voted that the recommendation to pay for employees' and guests' meals out of the entertainment account be accepted.

Discussion of communication between members of the Board of the Mabel Smyth Building and the Council followed. It was felt that information should be made known to HMA since HMA could be liable for expenses.

ACTION:

It was voted to accept the recommendation that information resulting from Board meetings of the Mabel Smyth Building be made known to HMA Council.

The Treasurer advised that it has been the Association's policy to provide HMSA coverage for employees beginning with the first day they are placed on the permanent payroll. He recommended an exception to the policy in the case of Mr. William Dodge in order that he may continue his policy without interruption.

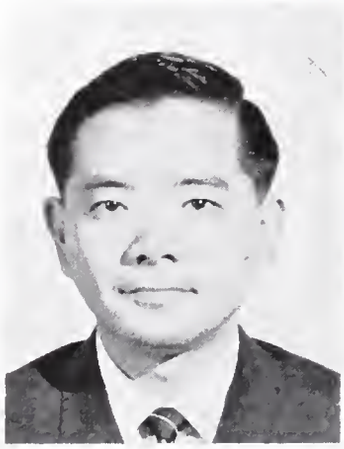
ACTION:

It was voted to waive the three-month waiting period and cover Mr. William Dodge with the

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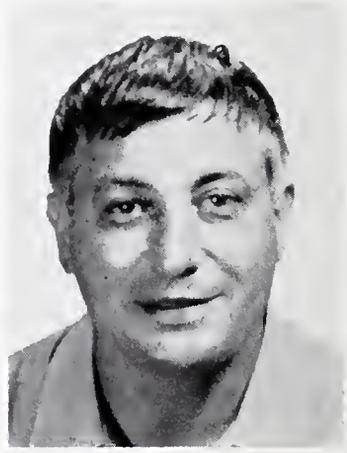
New Members



Richard Wei Min Dang, M.D.
1441 Kapiolani Blvd.
Honolulu, Hawaii 96814
DERMATOLOGY
Northwestern University, 1957
Internship—University of Minnesota Hospitals
Residency—University of Minnesota Hospitals



Frank S. Akamine, M.D.
1409 Kalakaua Avenue
Honolulu, Hawaii 96814
GENERAL & THORACIC SURGERY
Loma Linda University, 1954
Internship—Harper Hospital
Residency—Wayne State University Hospital
Alameda County Hospital
Children's Hospital of East Bay



René Joyeuse, M.D., M.S.
Molokai Clinic
Kaunakakai, Hawaii 96748
GENERAL SURGERY
University of Paris, 1954
Internship—St. Antoine Hospital
Residency—Mayo Foundation & Mayo Clinic
UCLA, Thoracic Surgery Division
Postgraduate—M.S. in Surgery
University of Minnesota



Willard Yasuo Miyahira, M.D.
1481 S. King Street
Honolulu, Hawaii 96814
INTERNAL MEDICINE
St. Louis University School of Medicine, 1958
Internship—Queen's Hospital
Residency—Northwestern University Medical Center



John Carlton Roberts, M.D.
2511 East Manoa Road
Honolulu, Hawaii 96822
ANESTHESIOLOGY
Yale School of Medicine, 1953
Internship—Lancaster General Hospital
Residency—Hartford Hospital



Ghim Leong Yeoh, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
RADIOLOGY
University of Nebraska, 1957
Internship—University of Minnesota Hospitals
Residency—Yale University New Haven Hospital

HAWAII MEDICAL JOURNAL

County Society News

Hawaii

The December 9 meeting was held at the Hilo Hotel. A letter from Mr. J. R. Veltmann was read. It set forth the action of the Honolulu County Medical Society's Board of Governors which unanimously disapproved the appointment of the proposed assistant medical director of HMSA. It was voted to withhold comment. A letter from Dr. Katherine Edgar of the Department of Health was read. She advised that she would investigate the possibility of using the EKG machine on private patients. The proposed State Medical Examiner System was discussed. The meeting concluded with a talk on "Surgical Treatment of Peptic Ulcer" by Dr. Henry Harkins.

Honolulu

Approximately 257 members were present at the December 3 meeting. The following new members were introduced: Drs. Truett V. Bennett, Max Gerald Botticelli, Edward L. Chesne, Reginald C. H. Ho, and Arthur Wright Neilson. Tellers were appointed and announcements preceded the review of annual reports. The Charter & Bylaw Committee recommended that the delegates to the HMA be directed to propose changes in the HMA Bylaws in respect to the following: (1) Chapter 3, Section 4. That each component society shall elect such delegates to serve a term of not less than two years, and to amend the terms of office for alternates to a term as decided by each component society, (2) That life membership shall begin in the HMA at the age of 65. Dr. Randal Nishijima gave the report of the Medical Practice Committee from the podium. The Resolutions Committee recommended the discontinuance of reading obituaries at Society meetings. It was voted that except in special cases, the executive secretary will automatically send a letter of condolence to the immediate family of the deceased members.

Mr. Gabriel Rogers was introduced as the BME's manager. The new officers of the Woman's Auxiliary were presented with leis.

Dr. Tomita elaborated on his President's Message. The following new officers were installed: President, B. A. Richardson; President-Elect, Robert T. Wong; Secretary, John J. Lowrey; Treasurer, George H. Mills.

' ' '

Approximately 300 members attended the January 7 meeting. Dr. Niall M. Scully introduced panelists—Martin Anderson, Walter G. Chuck, Myer C. Symonds, Frank W. Clay—who discussed "Forensic Medicine—Medical Malpractice."

After announcements by the President, Dr. George Mills introduced Messrs. Robert L. Thomas and Murray Klutch from the California Medical Association. They spoke on fee surveys and the methods used to establish a relative value study.

Kauai

The January 7 meeting was held at the G. N. Wilcox Memorial Hospital. Guests present were Drs. A. K. Cockett and J. Battista.

The following announcements were made: Dr. George Ewing will be on Kauai February 11 to see private and BCC patients in connection with the convulsive therapy clinic. The Queen's Hospital lectures are available on tape through Dr. Joseph Stokes. Dr. Goodhue was accepted by HMSA as a replacement for Dr. S. R. Wallis on the Review Committee. A new film "Coronary Arteriography" is available through the Health Department. The Maternal & Perinatal Mortality Study Committee will visit Kauai on January 14.

Committee appointments were presented. Four students were selected to participate in the February 21 Careers Day program in Honolulu. Dr. Boyden gave a report on the proposed two-year Biomedical Science School at the University. The President announced that a questionnaire on legislative items would be circulated and the results tabulated for presentation to the Council on January 29. Plans were made to entertain local legislators at a dinner meeting, and to submit a request to the HMA for reimbursement. The Mental Health Planning Committee is scheduling a Kauai meeting to discuss proposed mental health programs.

The meeting concluded with a talk on "The Diagnosis of Renal Hypertension" by Dr. Abraham K. Cockett.

Maui

Members and their wives met with Dr. Andrew C. Ivy, Jr., on October 15 to hear more about the HMA's public relations program. Dr. René Joyeuse was elected to membership in the Society. Correspondence from the Workmen's Compensation Bureau was discussed and the previous recommendation of the Society relative to office calls was reconfirmed. The membership agreed to support restoration of Dr. Baldwin's dispensary. It was agreed to submit the names of Drs. Wong, Tompkins, and Underwood for the Mental Health Committee. Plans were made for Community Health Week activities. A mock casualty drill involving a bus-truck collision will be held at Baldwin High School. It was voted to furnish lunches for the student volunteers. A nominating committee of past presidents was appointed. The November meeting was canceled and Kaanapali selected as the site for the Christmas Party.

' ' '

The annual meeting was held on December 17. The Society went on record as suggesting to Dr. Mills that it thought the efforts of the Hawaii Heart Association on Maui were unnecessary at this time. The following officers were elected: Drs. James F. Fleming, President; Marion L. Hanlon, Vice President, and Kenneth A. Haling, Secretary-Treasurer. Dr. McArthur announced that Mr. Dick Layton of AMPAC would hold a breakfast meeting at the Maui Palms on December 20 for doctors interested in politics.

' ' '

Dr. Hugo Moeller, who discussed peptic ulcer, was the guest speaker at the January 10 meeting. It was voted to accept Dr. Stokes' offer of tape records on visiting professors' lectures. The 1964 dues were set at $175, to include $151 for the AMA, HMA, and HAWAII MEDICAL JOURNAL. Dr. Pfaeltzer was nominated for the HMA Automotive Safety Committee and Dr. Moran for the Medical Education Committee. It was voted that the President be authorized to submit three names to serve on the HMSA Board of Directors. ■

HAWAII MEDICAL JOURNAL

Notes and News

New Offices for . . .

Dr. Robert P. Jay, in general practice at Ewa Plantation Hospital.

Dr. Garton E. Wall is associated with Alsup Clinic for the practice of general medicine.

Dr. Frank S. Akamine has opened his office for the practice of thoracic surgery at 1409 Kalakaua Ave.

Dr. Samuel L. Yee has moved to the Continental Bldg. at 1521 South King St.

Health Tips in the News . . .

The recent unanimous verdict of the U. S. Surgeon General's Advisory Committee, linking cigarette smoking with certain lung diseases, dropped a shell into the activities of the State Health Department. State Representative **Frank W. C. Loo,** Oahu Democrat, asked **Dr. Leo Bernstein** to prepare a list of recommendations to prevent or lessen the damaging habit of cigarette smoking among the people of Hawaii. **Drs. Walter Quisenberry** and **Doris Jasinski** of the State Health Department were in full accord with the study and felt that emphasis on "youth and prevention" was most important. **Dr. Rodney T. West** also stated that "our greatest concern is the teenager who hasn't picked up the habit yet."

Dr. George Sehnaek, President of the Hawaii Psychiatric Society, and **Mrs. Sylvia Levy,** Executive Director of the Mental Health Association of Hawaii, gave some down-to-earth hints on maintaining good mental health: "Permit a freer expression of emotions, but keep them under control to the extent that they don't get you into trouble; express them in acceptable ways. From time to time, maybe, quit your job if it's wearing you down."

Dr. W. F. Lyons, State Health Department epidemiologist, states that an estimated two-thirds of Hawaii's children under three years of age haven't received any polio immunizations. Such apathy, he cautioned, could lead to serious consequences.

Dr. Donald Jones likened the playing of football by a boy in the ninth grade to the "giving of high heels, lipstick, and 'falsies' to a 10-year-old girl." Furore continued over the dangers of football, first pointed out by **Dr. Frank Tabrah** in the HMA JOURNAL three issues ago. Dr. Jones was especially concerned about boys under 13, since injury to an epiphyseal plate at this age may cause future growth arrest.

Syphilis is on the rise in Hawaii, says **Epidemiologist Lyons.** In 1955, only one case was reported. In the last two years about 58 cases have been reported in the State, approximately half in homosexuals.

Happy Notes . . .

Dr. Richard Pang has passed his Boards in thoracic surgery and was congratulated by the surgical staff of St. Francis Hospital.

Linda Lizbeth, daughter of **Dr. Walter B. Quisenberry,** was wed to Dr. Arnold Lewis Green in a Christmas Day ceremony. The young people will make their home in Rochester, N. Y., where Dr. Green teaches anthropology at the university.

Ruth Silbiger of Vienna became the bride of **Dr. Robert G. Benson** in Honolulu. The best man was his brother, **Dr. Homer Benson.**

Dr. Charlotte Kutsunai and **Dr. James Krejei** were married at the Central Union Church. They will reside in Burbank, Calif., and the bride will teach anesthesiology at L.A. County General Hospital. Her husband is taking a residency in the same specialty.

Elected as Fellows of the American College of Physicians were **Drs. Joseph Stokes III** and **Raymond deHay. Dr. Charles T. H. Ching** has been elected an Associate.

One of 117 students named to the Fall Academic Honor List at Claremont Men's College, we are informed by the school, was Thomas Nance, son of **Dr. and Mrs. Francis D. Nance.**

Miscellany . . .

A full page in the *Star-Bulletin* covered the weird story of LSD-25, that strange drug that "telescopes time into brilliant kaleidoscopic moments of eternity." Some people when on the drug, according to **Dr. William H. Stevens,** have gone back into time so far that they spanned the scale from vertebrate to invertebrate, ending up as a single cell in some primordial ooze. "It's the Bridey Murphy story all over again," he said, according to Reporter **Tomi Knaefler.**

Advertiser's **Bob Jones** made a hit with his front-page probe into the crack-pot field of Scientology. Sessions which he attended featured the Hubbard Electrometer, which is said to measure from minus-8 (hiding) to plus-40 (serenity of beingness). He also was able, for the price of $2.50 and no training, to become a licensed "Psychologist," thus enabled to operate the "Bob Jones Personal Consultant Center for Emotional Problems."

Newer techniques in anesthesia were featured in a half-page article in the *Star-Bulletin*. Fluothane replacing ether; Sucostrin replacing curare; hypothermia and spinal anesthesia and quiet efficiency have replaced the ancient den of horrors that was the pre-anesthesia operating room, it was reported.

Latest statistical picture of Hawaii's health was pub-

THOMAS HENRY TAMURA, M.D.
1898-1963

Dr. Thomas H. Tamura was born in Paauhau on the island of Hawaii on September 26, 1898. After graduating from McKinley High School in Honolulu, he entered the University of Missouri. He received his M.D. degree from Yale University in 1922.

Dr. Tamura interned for one year at the New Haven Hospital in Connecticut and then returned to Hawaii. He practiced at Honokaa for seven years, then moved to Waipahu and operated his own hospital at Waikele.

Ill health forced Dr. Tamura to retire from active practice. In 1958 he moved to Alexandria, Virginia, where he died on February 20, 1963. Dr. Tamura is survived by three daughters—Dorothy (Mrs. Martin Mangan), Bess (Mrs Harvey Littleton), and Louise (Mrs. N. Lyle Eberhart), and one son, Thomas Lyle. His wife, the former Mathilda Ziegelhoefer, died in 1959.

lished by the State Health Department. Leading causes of civilian deaths in 1963 were: heart disease, 1206; cancer, 565; stroke, 313; diseases of early infancy, 238; all forms of accidents, 230; influenza-pneumonia, 139; congenital malformations, 94; diabetes mellitus, 86; suicide, 58; cirrhosis, 48; kidney diseases, 37; all others, 488. There were 12 new cases of Hansen's disease. According to **Dr. Maurice Brodsky,** assistant director of Leahi Hospital, TB admissions have dropped from 380 in 1962 to 321 in 1963. Filipino is the leading ethnic group in susceptibility to tuberculosis. Hawaii's TB rate was 46.4 per 100,000, as compared to a national average of 29.4 per 100,000. A recently completed life expectancy table shows that men in Hawaii have a life expectancy of 74 years, as compared to 66.5 for the nation as a whole. The figures for women were similar, with 78.1 years for Hawaii and 73 for the U.S. as a whole.

The Hawaii Heart Association is spending $33,000 in health research in the state this fiscal year. This is a 40 per cent increase over the previous year. This year's grants went to **Dr. Paul Gebauer,** to conduct studies on use of skin grafts in cardio-vascular surgery; **Drs. Doris Hilker, Philip C. Loh, Richard T. Maniya,** the Hawaii Cardiovascular Study, **Drs. Yasuo Takenaka** and **Kerry T. Yasunobu.**

Local Contributions to Medical Literature . . .

"Acute Mercurial Intoxication Treated by Hemodialysis," by **Dudley S. Seto** *et al.*, in the November, '63 *Annals of Internal Medicine.*

"Urbanization and Squatter Resettlement as Related to Child Health in Hong Kong" and "Health Trends in China since the 'Great Leap Forward'" by **Robert M. Worth** in *American Journal of Hygiene.*

"Technology for Rapid Identification of Virus Isolates" by **Leon Rosen** in *American Review of Respiratory Diseases,* September, '63.

"Development of an Effective School Tuberculin Testing Program in Hawaii" by **Dr. Nathan Shklov** in the January, 1964, issue of the *Journal of School Health.*

Medical Training . . .

A three-day lecture series on diabetes was given by **Dr. Robert Tranquada,** a former Island resident, now Assistant Professor of Medicine at U.S.C. Among the pearls: studies now under way may produce within the next five years methods for biopsy and special blood tests which will enable physicians to diagnose diabetes long before classical symptoms occur.

The "Feasibility Study" for the six-year biomedical science school and two-year medical school at the University of Hawaii, now renamed the "Planning Study" and under the guidance of **Dr. Richard Lockwood** of U.C.L.A., continues in the limelight of local interest. Dr. Lockwood replaces **Dr. Robert Tschirgi,** formerly in charge of the study. The Board of Trustees of The Queen's Hospital, and the Legislature, have already gone on record as favoring the program. St. Francis Hospital was still considering when we went to press.

This planning study is financed by a New York foundation, the Commonwealth Fund. A local committee, chaired by Frederich Simpich, Jr., president of Oceanic Properties, will try to encourage industry in Hawaii to raise support for all of the nation's 88 medical schools and Hawaii's, if we get one. The only physician of the committee is **Dr. Rodney T. West.**

A statewide conference on pulmonary diseases was sponsored by the Hawaii Thoracic Society and the Academy of General Practice. Stressed was chronic lung disease, its diagnosis and management. **Drs. James Ball** and **Gilbert Ching** emphasized the importance of cigarette smoking as a causal agent in certain chronic lung diseases. **Drs. Unoji Goto** and **Bernard Yim** then discussed the recent developments in pulmonary disease diagnosis. Dr. Goto lit up a cigarette at the conclusion of his talk. Beer and pretzels were served by courtesy of the Pfizer Co.

U.S.C. will again conduct a P-G refresher course in Honolulu and Maui on August 3-10. In addition to the U.S.C. faculty, **Drs. Sheila Sherlock** and **Geraint James** of London will conduct several morning sessions. Tuition: $100.

An educational T-V program, even for MD's, is our own "Call the Doctor" session on KTRG, Channel 13, Sundays at 9 p.m. It's a must, as much as is reading the medical articles in *Reader's Digest* and *Time.* Recent shows concerned "Rheumatic Heart Disease," mouth-to-mouth resuscitation, hangovers, Fedicare, and sight saving.

Don't miss the annual HMA meeting, April 29–May 3, at Princess Kaiulani. The program will be centered on Cardiovascular Diseases. Guest speakers will be **Drs. Irvine Page, Thomas Starzl, John J. Kelly, Frank Gerbode, Edwin Wiley,** and **William Sheeley.**

Names in the News . . .

The rapid growth of nuclear medicine in Hawaii was glorified by the *Star-Bulletin's* **Tomi Knaefler,** when she described the newly-formed Nuclear Medicine Department at The Queen's Hospital, under the direction of **Dr. Robert Nordyke.** The advantages of using radioisotopes in diagnosis were discussed. Queen's now receives 20 dif-

continued page 312

YOUNG POLK KANG, M.D.
1895-1963

Dr. Y. P. Kang was born at Wonsan in Korea on June 17, 1895, the son of In Nok and Marian (Lee) Kang. At the age of 19 he came to Honolulu and enrolled in Mid-Pacific Institute. He received his B.S. from Roanoke College, and his M.D. in 1928 from Emory University School of Medicine in Atlanta.

After interning at St. Francis Hospital he became house physician there, and then became the hospital's anesthesiologist, a position he held for some time, until he entered private practice.

During World War II Dr. Kang taught first aid courses, and he and Mrs. Kang frequently entertained service men and civilians in wartime service at their Makiki Street home. In 1943 Dr. Kang served as a Major in the Hawaii Defense Volunteers, and in 1945 joined the Hawaii Territorial Guard.

Dr. Kang was active in Korean community affairs, and served as Treasurer and a member of the Board of Directors of the Korean Christian Institute. He was a past president of the Korean Chamber of Commerce, the Korean University Club, and the Korean American Club. He belonged to the Korean Christian Church.

Pulmonary emphysema and cor pulmonale compelled Dr. Kang's retirement from practice in 1959, and he died on September 29, 1963, of coronary occlusion. He is survived by his wife, the former Mary Kim, one daughter, Rosaline (Mrs. M. A. End), and two sons, Ronald Y. K. and Young Polk, Jr.

HAWAII MEDICAL JOURNAL

Book Reviews

★Pediatric Cardiology, 2d Ed.

By Alexander S. Nadas, M.D., F.A.A.P., 828 pp., $16.00, W. B. Saunders Company, 1963.

FOR THOSE PEDIATRICIANS who are interested in more than second-hand knowledge about cardiology as it pertains to pediatrics, this book is recommended. The tremendous advances made in both congenital and acquired heart disease over the past several years require much more than a screening knowledge of cardiology by the astute pediatrician. Although this particular book does not go into a lot of the periphery of cardiology such as the physiological dynamics in various diseases, it does give an excellent picture of the history, diagnosis, physical findings that the clinician needs to know.

In addition, there is a good section on electrocardiography.

One of the things that I enjoyed about this book was that the author speaks frequently in the first person. In short, he is telling you what *he* believes about the findings or the therapy in a disease, as opposed to so many books which simply tell you that Dr. X treated 3,000 cases and got such and such results, whereas Dr. Y treated 2,500 cases and got slightly different results. Nothing is more frustrating to the average physician who is looking for information than to end up with different sets of figures which are a puzzle. At least, if one follows the dictates of this man, if something goes wrong he can put the finger on the source of blame!

I would recommend this book for the pediatrician's personal library.

MORTON E. BERK, M.D.

The Fundamental Ideas of Medicine

By J. F. A. McManus, M.D., 115 pp., $4.75, Charles C. Thomas, 1963.

THE HISTORY of medicine in seven chapters, each introduced by and in some sense developing one fundamental thesis regarding disease. The theses are so fundamental that most of them would be equally acceptable to a native witch doctor and a modern professor of medicine, but the treatment is thought-provoking and conveys a strong feeling of the intrinsic dignity of the healing art. Over 150 brief biographical notes are appended, and a bibliography of suggested readings in medical history.

HARRY L. ARNOLD, JR., M.D.

★Crossen's Synopsis of Gynecology, 6th Ed.

By Daniel Winston Beacham, M.D., and Woodard Davis Beacham, M.D., 371 pp., $7.50, The C. V. Mosby Co., 1963.

ALTHOUGH THIS BOOK was written for medical students as an aid to obtain a general understanding of gynecology, I found it extremely interesting and informative. Anyone interested in gynecology will find this text helpful. The chapter on gynecologic examination and diagnosis is particularly well done. Pelvic examination, to one who is not familiar with the anatomy and the technique of performing it, is difficult and perplexing. By using this chapter as a guide, even practitioners who specialize in this field will find the procedure useful and rewarding. The illustrations in this and other chapters are excellently done and help the reader understand some of the more difficult explanatory remarks in the text. For those who need detailed working knowledge of gynecology, a standard textbook is required, but this synopsis can be used as a means of brief review of points that may need clarification later. The practicing physician will also find this synopsis helpful in arriving at tentative diagnosis quickly and easily. The present authors, Beacham and Beacham, have done an excellent job updating this excellent book. Anyone who wishes to review the field of gynecology in a minimum of time will find this book helpful.

GEORGE GOTO, M.D.

★ means highly recommended.

Electrocardiographic Notebook, 2d Ed.

By M. Irené Ferrer, M.D., 112 pp., $2.75, Hoeber Medical Division, Harper & Row, 1964.

THIS SHORT SUMMARY of beginning electrocardiography is another of the myriad of similar books on this subject. As a primer it is readable and describes the major electrocardiographic abnormalities in understandable terms. It has several tables of normal values for the component parts of the electrocardiogram. Personally, however, I object to the use of so many abbreviations and think, like Dr. William Bean of Iowa City, that we should use complete words in a text. All in all, this book is just another primer in this field.

D. B. BELL, II, M.D.

Blood Diseases

By M. A. Atamer, M.D., 616 pp., $16.50, Grune & Stratton, 1963.

HEMATOLOGISTS would be interested in this excellent book as a quick reference, particularly for the statistical data in the form of tables at the end of each chapter. The author has painstakingly compiled the clinical, laboratory and therapeutic aspects of each disease, with excellent references.

Other practicing physicians will find that the concise treatment of each disease makes this book ideal for reference.

This treatise on blood diseases can hardly be considered a standard "text" for students. It does not attempt to classify hematologic disorders, as for example, intracorpuscular vs. extracorpuscular hemolytic diseases. No chapter has been devoted to normal hematopoiesis, normal coagulation sequences and techniques, or laboratory methods.

NOBORU OISHI, M.D.

The Care of the Geriatric Patient, 2d Ed.

Edited by E. V. Cowdry, Ph.D., Sc.D. (Hon.), F.R.M.S. (Hon.), 566 pp., $11.85, The C. V. Mosby Company, 1963.

WHO wants to care for old folks? What can we do for them, anyway?

It is our fault—clinicians and public health workers—that people are living longer, and that there are more and more elderly patients who call for our attention. The intern, the clinician, the specialist (exclude only the obstetrician and the pediatrician!) will meet the increasing problems of geriatrics. Here is a book from which all may profit. Although its size has increased from 416 to 546 pages, plus index, it is still compact (5" x 7½" pages). In spite of multiple authorship, for the most part, it is highly readable.

By far the best chapter, completely re-written by the original author, is the one on rehabilitation. Any doctor could profit by it, especially pages 461-468, a gem of narration entitled "The Reader Has a Stroke."

continued page 308



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Reading a Letter

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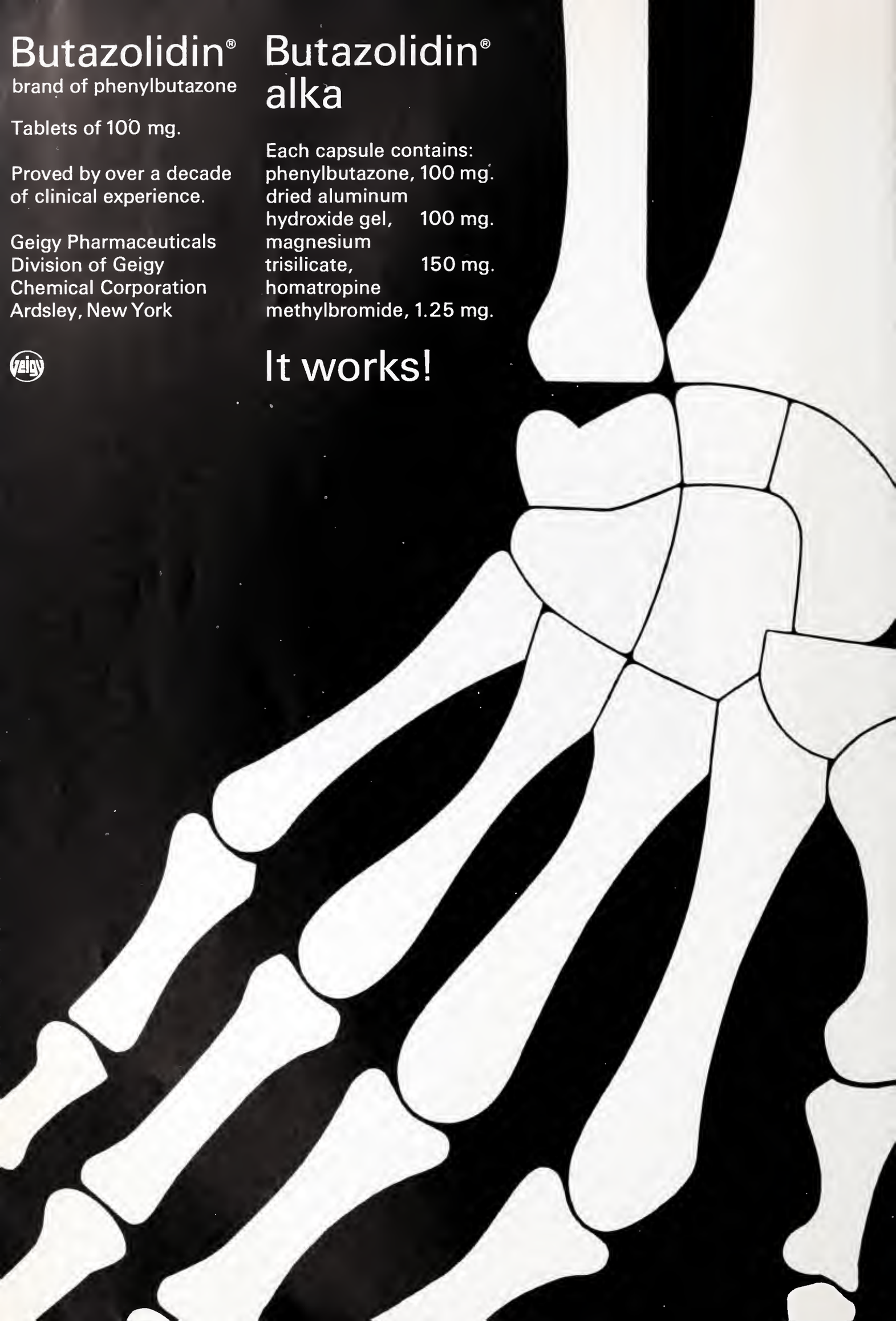
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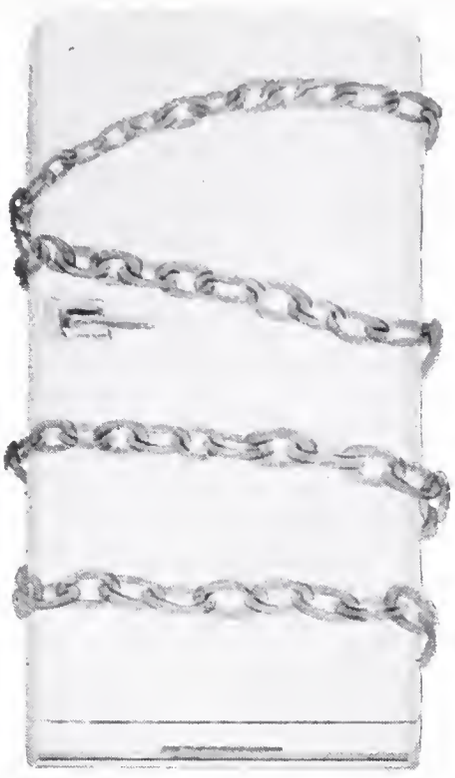
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Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: JAMES YANO, Kaiser Foundation Hospital

Who's Who

HAWAII STATE HOSPITAL

Miss Marguerite Beatty, originally from Stafford, Kansas, is the Chief Medical Technologist at the Hawaii State Hospital laboratory department. She has been with the State Department of Health for the past 12 years, and in her present place of employment since 1957. Since February of last year, the laboratory facilities have been relocated into new, modern quarters. Psychiatric patients may contract the same physical illnesses as other people in the community; therefore, for the most part, the same clinical laboratory tests are performed as in other hospital laboratories, except that greater emphasis is given to parasitic infections and enteric pathogens. Other medical technologists under her supervision are Betty Hughes, Henry Nosaka, Gretchen Asato, and an EEG technician, Esther Gibson.

STRAUB CLINIC

The Chief Medical Technologist at Straub Clinic since 1928 is Mr. Massao Tanaka, from Makaweli, Kauai. Having been the first laboratory technologist at "The Clinic," he has witnessed the vast growth of the medical facilities there. Recently the entire clinical laboratory has moved to a very spacious and modern quarters in the newly constructed addition. Under the directorship of Dr. I. L. Tilden, pathologist, the laboratory is staffed by a biochemist, Kazuto Yamada, and the following medical technologists: Grace Kagawa, Kaname Saito, Gertrude Ching, Edith Maeda, Marian Tanaka, June Fukunaga, Jean Nishimura, Deanne Horie, and Clara Nagao.



HSMT MEMBERS CONFER—*Seated, left to right: Marguerite Beatty, State Hospital; Edith Eckstein, U. S. Army Tripler General Hospital. Standing, left to right: Massao Tanaka, Straub Clinic; Dorothy Matsuo, Pathologists' Medical and Cytology Laboratories.*

PATHOLOGISTS' MEDICAL AND CYTOLOGY LABORATORIES

Mrs. Dorothy Matsuo, a graduate with a degree in medical technology from the University of Hawaii, is the Chief Medical Technologist at the Pathologists' Medical and Cytology Laboratories in Honolulu. Organized a few years ago, the laboratory is under the joint directorship of Drs. Paul Tamura, Harold Civin, Grant Stemmermann, and Arturo Salcedo. Other medical technologists under the supervision of Mrs. Matsuo are Kenneth Sato, Richard Kurisu, Beryl Aragaki, and Sally Tilden. A recent addition to their staff is Dr. Quentin Belles, a biochemist, who will be in charge of the special chemistry department. His assistant is Mrs. Marian Littleman.

U. S. ARMY TRIPLER GENERAL HOSPITAL

One of the civilian supervisors in medical technology at U. S. Army Tripler General Hospital is Miss Edith Eckstein. She received her baccalaureate degree in Medical Technology from Temple University and did further studies at Rutgers University, University of Nebraska, and the University of Hawaii. Before being transferred from New Jersey to Tripler Hospital in 1956 as the civilian supervisor in charge of the blood bank department, she was employed by the State Departments of Health in Delaware and New Jersey. Presently, Miss Eckstein is also the assistant to the Director of the School of Medical Technology at Tripler Hospital, Colonel Slater M. Dozier.

With an official capacity of 1,000 beds, U. S. Army Tripler General Hospital is one of the largest and most modern Army hospitals in the country. The laboratory department under the Chief of Pathology Services, Colonel Dozier, and his assistant, Lt. Colonel Robert Kellenberger, has a staff

of over sixty members which includes officers, enlisted personnel, and civilians. Other military members of the laboratory staff include Major Harvey Graham, Chief of Clinical Pathology Services; Major Benjamin Veltri, Chief of Microbiology, and Teaching Supervisor of the School of Medical Technology, and Captain George Bunce, Chief of Biochemistry. Civilian supervisors besides Miss Eckstein are as follows: Ann Wong, Bacteriology; Wilson Wong, Chemistry; Evelyn Bishop, Special Chemistry; Lillian Tanaka, Histo-pathology; Takeo Saito, Cytology; Hajime Imada, Hematology; Kitty Hardeck, Special Hematology; Hing Lim, Cytology. In their School of Medical Technology this year, they have six interns: Ellen Ebisu, Linda Fu, Ava Lee, Samuel Tucker, Gretchen Corban, and Vernon Moore.

Convention in May

Plans are being formulated for the forthcoming Fifteenth Annual Convention of the Hawaii Society of Medical Technologists which is to be held May 14-16 at The Queen's Hospital. Mr. Charles H. Humes of Coleman Instruments, Inc., has been invited to be the principal speaker. Since the spectrophotometer plays a very important role in every clinical laboratory, he will elaborate on the principles and mechanism of spectrophotometry and will conduct a workshop on instrumentation. In recent issues of medical and paramedical literature, the subject of quality control in all phases of laboratory work is frequently discussed.

What could be more appropriate at this time in the quest for quality control than to attend a workshop to increase one's knowledge on the spectrophotometer, since this instrument is used countless of times daily to quantitate chemical determinations. Are you familiar with the method of monitoring your spectrophotometer according to Dr. Wendell T. Caraway, biochemist of the Flint Medical Laboratory in Flint, Michigan, or the method proposed by Mr. Humes in evaluating the stability of the spectrophotometer with weekly checks using a nickel sulfate standard solution? When are we to know if the exciter lamp is aging, or excess stray light is being reflected from bulbs or lenses, or band width of light is correct?

In charge of this convention is Miss Phyllis Sonoda of Queen's laboratory staff. Assisting her in the project is an advisory board—Grace Kagawa, Ann Stegmaier, and Elaine Chang. Tentatively, according to banquet chairman Alice Tonchon, the Willows Restaurant has been selected as the site of our annual celebration. Members of the HSMT are asked to participate in this educational session and to give it their fullest support. All inquiries concerning the convention should be directed to Miss Sonoda, at 589-011 extension 387.

A Hospitality Committee headed by Edith Eckstein will assist other island delegates in attending this convention.

Candy Sale—Success!

Congratulations are in order to Miss Clara Nagao, the chairman of the recent See's candy sale for the HSMT annual fund raising project. She did a marvelous job coordinating and supervising the entire undertaking. Of course, congratulations are also in order to all members who played an active role in the distribution and sale of the candies. Proceeds from such events are used to send a delegate to the Annual National Convention of the American Society of Medical Technologists, for use by our Scholarship Committee, and to help defray expenses incurred by HSMT throughout the coming year.

Election of Officers

The election of the officers for the Hawaii Society of Medical Technologists—President-elect, Recording Secretary, Corresponding Secretary, Treasurer and two members to the executive board —will take place at the annual meeting of the HSMT in May. The chairman of the nominating committee is Mrs. Dorothy Matsuo.

Announcements

Scheduled to attend the annual ASMT convention in Kansas City this June as official delegates of the HSMT are Kenneth Sato, President-elect, and Louise Wulff, Instructor of Medical Technology at the University of Hawaii.

A revised mailing directory for the HSMT is in the process of being made, so please notify Frances Koike at the Blood Bank of any recent changes of addresses. ■

HSMT ANNUAL MEETING

MAY 14-16

THE QUEEN'S HOSPITAL

This Is What's New! *continued from 296*

hamsters only if the thymectomized female was treated with testosterone or subjected to bilateral oophorectomy. In addition to wasting away, the disease was characterized by atrophy of all lmyphoid tissue, pancytopenia, and decreased gamma globulins. The disease in the thymectomized male hamsters resembles the human disease known as **alymphocytosis.** (*Blood* [Sept.] 1963.)

• Investigators at the University of Minnesota, on the basis of clinical and experimental studies, suggest a theory of **irreversible shock** based on mechanical limitations of blood flow to visceral organs. This was produced by hemorrhage, endotoxins of gram-negative bacteria, epinephrine, or occlusion of the superior mesenteric artery. Vasopressors may actually potentiate shock by increasing visceral ischemia. In patients not responding to the administration of blood they recommend **intravenous hydrocortisone** and generous volume of **plasma** dependent on careful observation of the central venous pressure. **Phenoxybenzamine** in a dose of one mg per kilogram intravenously is advised in patients who do not respond to hydrocortisone and plasma. (*J. Clin. Pharm. & Ther.* [Jan.-Feb.] 1964.)

• **Peculiar lymphocytes** characterize **schizophrenia.** Schizophrenia was correctly diagnosed in 49 of 50 pairs of blood smears studied. Whether the lymphocyte and reticulum cell abnormalities noted reflect endocrine, immune, or genetic disturbance in pathogenesis remains unknown. (*J.A.M.A.* [Jan.] 1964.)

• We tend to over-estimate the breadth of the spectrum of the blood-spectrum antibiotics. Recently, in England and the United States, there have been reports of **pneumonia** caused by **tetracycline-resistant pneumococci.** The authors emphasize the danger of the indiscriminate use of tetracycline for the treatment of suspected pneumococcal pneumonia. (*New Eng. J. Med.* [Jan.] 1964.)

F. I. GILBERT, JR., M.D.

Book Reviews *continued from 302*

Five new chapters have been added in this edition: Cardiovascular (by Paul White), Orthopedic, Dermatologic, Sexual, and Urologic aspects.

Use of interesting and informative case reports is a feature of the book. These are found in the chapters on Sexual, Surgical, and Nursing aspects, and those on Home Care and on Rehabilitation.

Subjects of importance, not usually found in clinical texts, are Hospitalization, Selection of a Nursing Home, Homes for the Aged, Geriatric Training, Community Programs and Services, and Geriatrics around the World.

If you are interested in *care*—as well as *cure*—this is for you!

NORMAN R. SLOAN, M.D.

Also Received

Mental Mechanisms

By Henry P. Laughlin, 272 pp., $7.50, Port City Press, Inc., 1963.

FOR PSYCHIATRICALLY oriented generalists, or medical students.

Manual of Clinical Nutrition

By Robert S. Goodhart and Michael G. Wohl, M.D., 279 pp., $5.50, Lea & Febiger, 1964.

GOOD REFERENCE handook.

The Quiet Flame

By Eve K. Betz, 150 pp., $2.50, The Bruce Publishing Co., 1963.

A CHILDREN'S BOOK about the role of the Franciscan nuns at Kalaupapa Settlement.

An Introduction to Respiratory Cytology

By Winifred Liu, M.Sc., M.D., 115 pp., $5.75, Charles C. Thomas, 1963.

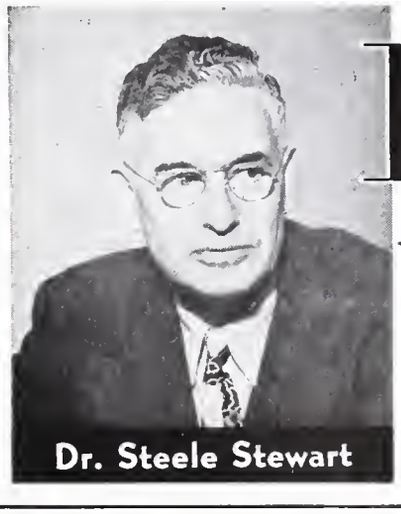
FOR CYTO and technologists. This volume is indispensable.

Clinical Metabolism of Body Water and Electrolytes

Edited by John H. Bland, M.D., 623 pp., $16.50, W. B. Saunders Co., 1963.

MULTI-AUTHOR SYMPOSIUM with clinical orientation. It may be a third edition (a second was alluded to on page IX).

continued page 310



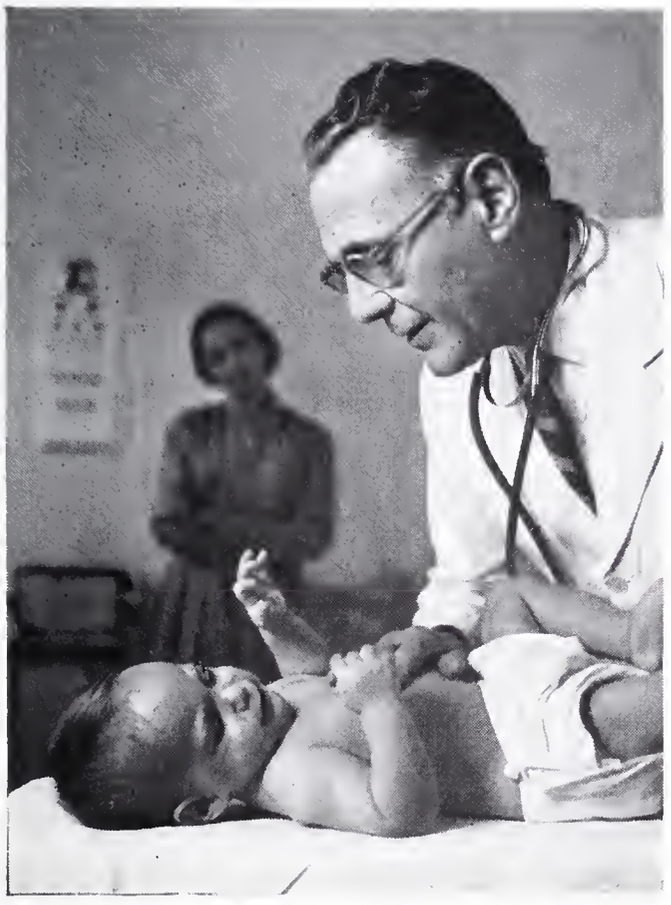
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References: 1. Wilson, J. F.; Heiner, D. C., and Lahey, M. E.: J. Pediat. 60:787, 1962. **2.** Committee on Nutrition, Collected Reprints, 1956-1962, Evanston, Ill., American Academy of Pediatrics, 1963, p. 45. **3.** Beal, V. A.: Pediatrics 20:448, 1957. **4.** Reisner, E. H., Jr.: Penn. Med. J.: 63:49, 1960. **5.** Marsh, A., et al.: Pediatrics 24:404, 1959.

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Book Reviews *continued from 308*

A Synopsis of Gastro-enterology

By G. N. Chandler, M.D., D.M., M.R.C.P., 192 pp., $7.00, Williams & Wilkins, 1963.

BETTER FOR students than practitioners. Very British in style and spelling.

Progress in Medical Genetics, Vol. III

Edited by Arthur G. Steinberg, Ph.D., and Alexander G. Bearn, M.D., 266 pp., $12.25, Grnne & Stratton, 1964.

PRETTY ADVANCED stuff, but important to those with enough background to understand it.

★Techniques in Medical Communication

By Warner F. Bowers, A.B., B.Sc., M.D., M.S., Ph.D., F.A.C.S., $4.50, Charles C. Thomas, 1963.

A USEFUL, practical, crisply and wittily written manual of teaching and advice for medical speakers, writers, editors, and Medical-Meeting-Arrangements-Committee chairmen.

Perception and the Conditioned Reflex

By Ye. N. Sokolov, 309 pp., $11.24, Pergamon Press, 1963.

TECHNICAL neurological material; very basic is the dialectical materialistic philosophy. Pavlov, brought up to date, from Moscow.

Biology of the Prostate and Related Tissues

National Cancer Institute Monograph #12, 446 pp., $4.00, U. S. Government Printing Office, 1963.

BIOLOGISTS can hardly afford to miss this, of course. Beautiful illustrations, many of them electromicrographs.

continued page 314

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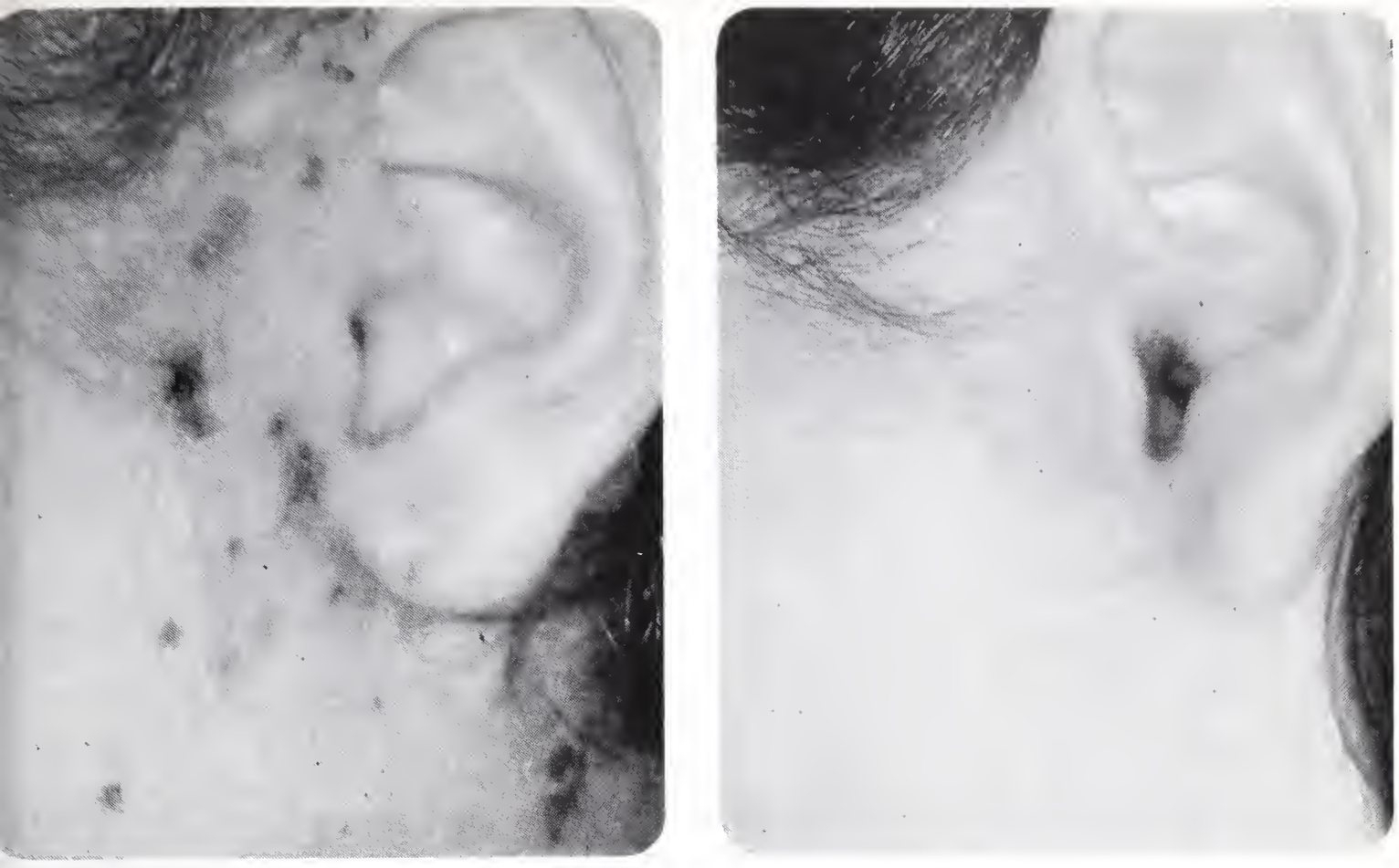


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B. B., Age 10—atopic dermatitis all her life...and after two weeks of treatment.

Case History: B. B. is a 10-year old girl with a life-long history of atopic dermatitis. Previous diet therapy, lamp treatment, and antihistamine were of no avail. First photograph shows a severely excoriated, eczematized area with intractable pruritus. ARISTOCORT® Triamcinolone Acetonide 0.1% Cream was prescribed, and relief was obtained in 24 hours. Follow-up photo was taken two weeks later.

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278-3

ferent isotopes from Oak Ridge, in order to perform many tests which were unknown not many years ago.

When the controversial **Dr. Linus C. Pauling, Sr.,** received his second Nobel prize, a cluster of lengthy articles appeared in the local press, with fresh and intimate facts furnished by his son, **Dr. Linus C. Pauling, Jr.** The first prize had been given to the noted biochemist in 1954 for his work on molecular structure, based on the sickling phenomenon of hemoglobin.

After a one-year stay in southwest Africa, the octogenarian **Dr. Sidney V. Kibby** told of his many interesting experiences practicing medicine in the bush. A friendly witch doctor in the area treated one violently psychotic African with excellent results, by administering roots and herbs—and hitting the patient over the head with a club.

Dr. Richard D. Moore is developing mammography as screening device for breast cancer at St. Francis Hospital, with help from a grant from the Hawaii Division, American Cancer Society. Another grantee of the Hawaii ACS is **Dr. Theodore Winnick,** professor of biochemistry and biophysics at UH and a cancer researcher for 17 years. He and his group of seven are probing the mysteries of the DNA molecule.

The four smiling faces of the Honolulu County Medical Society 1964 officers were spotted in the local press: **Dr. B. Allen Richardson,** President; **Dr. Robert T. Wong,** President-Elect; **Dr. John J. Lowrey,** Secretary, and **Dr. George Mills,** Treasurer (not smiling too broadly—money problems already?).

The Hawaii Chapter of the American College of Surgeons has elected new officers: **Drs. F. J. Pinkerton,** president; **Shoyei Yamauchi,** vice-president; **Carl Mason,** secretary-treasurer, and **K. S. Tom,** councillor.

Two Hiloans were the recipients of the newly organized medical scholarship fund of the HMA. **Wilfred Fujimoto** is now in his third year at Johns Hopkins Medical School, and **Thomas Eshelman** is in his first year at Bowman Grey School of Medicine at Winston-Salem, N. C.

The Hawaii Chapter of the Academy of General Practice has elected **Dr. Robert P. C. Ho,** president; **Dr. Walter Ozawa,** president-elect, and **Dr. J. I. Frederick Reppun** as secretary-treasurer. Chosen as directors were **Drs. Patrick Cockett** of Kauai and **F. K. Lam, Jr.,** and **Robert Bell, Jr.,** of Honolulu.

Government Rx . . .

Of the 207 leprosy patients at Kalaupapa, 136 are now free to leave, but have no desire to do so. Once thought of as "the last place on earth," to many Kalaupapa is home. The patients get houses, food ration tickets, free cigarettes, and additional spending money, and many work in the colony for about $170 a month. New cases are all sent now to Hale Mohalu in Pearl City, where 69 active cases are currently under treatment, according to **Dr. Ira Hirschy,** chief of Communicable Disease Division, State Department of Health.

The Food and Drug Administration has cautioned doctors that it may be hazardous to prescribe Enovid to women under 35, in spite of much recent evidence that incidence of thrombophlebitis is no higher in Enovid users than in the general population.

The State Medical Practice Act was called "awfully sick" by many Hawaii doctors. The criticism of Hawaii medical licensing procedures is not unique to Hawaii. Complaints are uttered all over the U.S. The worst point, some feel, is Hawaii's one-year residence requirement, the only one of its kind in the nation, presumably aimed at protecting the "local boys' " interests.

The Federal Hill-Burton construction funds for this fiscal year: $125,000 to Lihue Health Center; $80,382 to Kuakini Hospital; $14,000 to Molokai General Hospital; $73,837 to St. Francis Hospital; $200,000 to Kapiolani; $8,334 to Children's; $72,000 to Maluhia; $32,366 to Hana Clinic; $83,940 to Kahuku Hospital, and $116,894 to Hale Makua on Maui. Over $9.5 million has been allocated to Hawaii during the past 16 years.

Placement Service . . .

General practitioners are needed for American Samoa and Kwajalein.

Vacancies still exist in residency programs in medicine, surgery, OB and pediatrics at the major Honolulu hospitals. Vacancies for rotating interns also exist. Stipends are now $500 per month for interns and $550 for first year residents, increasing $50 per month for each succeeding year.

Hawaii Department of Public Health

COMMUNICABLE DISEASES IN HAWAII
December 1963–January 1964

DISEASE	DEC. 1963	JAN. 1964	FIVE-YEAR MEDIAN
Chickenpox	56	85	106
Conjunctivitis, Infectious	2	5	1
Dysentery, Amebic	6	—	<1
Dysentery, Bacillary	13	12	10
Gonorrhea	24	39	19
Hansen's Disease	3	—	1
Hepatitis, Infectious	7	8	3
Influenza	96	106	40
Measles	14	35	58
Measles, German	5	7	10
Meningitis, Aseptic	9	11	<1
Meningitis, Meningococcal	2	2	<1
Mumps	159	547	73
Pneumonia, Infectious	—	4	19
Rheumatic Fever	2	—	<1
Salmonellosis	51	54	16
Scarlet Fever	3	12	4
Streptococcic Sore Throat	177	143	8
Syphilis, Primary & Secondary	—	8	1
Syphilis, Early Latent	2	6	1
Syphilis, Late & Late Latent	9	14	6
Tetanus	—	3	—
Weil's Disease (Leptospirosis)	8	1	<1

Comments

Mumps trend has been up for 5 months. Chickenpox trend started up in November.

Influenza. Kauai reported 44 and 71 cases in December, January. No laboratory verification or virus studies have been reported.

Syphilis. Six of the primary cases were infected in S.E. Asia. Two were infected in ConUS. These patients were ALL located and treated before any contacts were made in Hawaii. Four were military.

Gonorrhea trend is up (due to better reporting? Thank you!). ■

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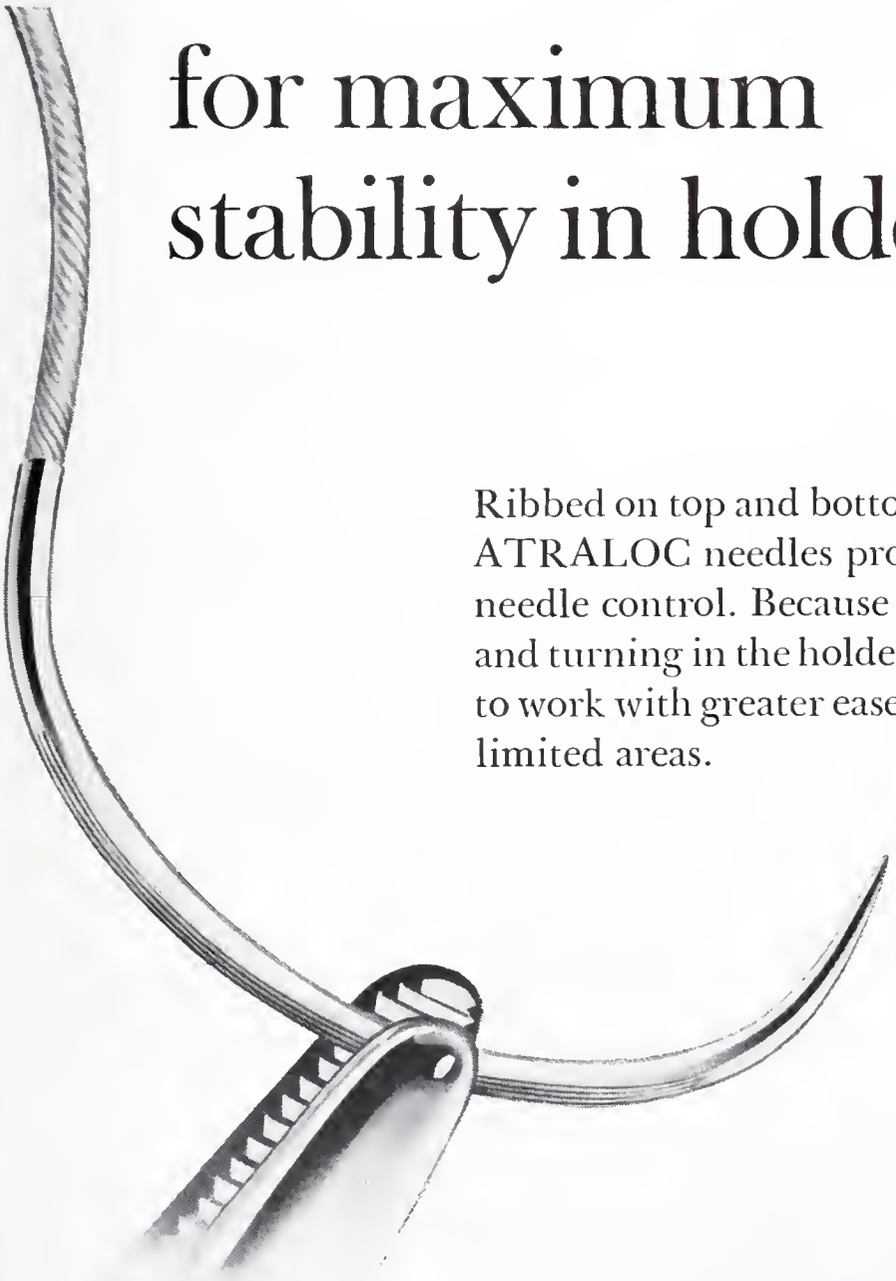
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Book Reviews *continued from 310*

The Postgastrectomy Syndromes

By E. R. Woodward, M.D., 56 pp., $3.75, Charles C. Thomas, 1963.

FIFTY PAGES and 69 references of obvious interest and value to minor abdominal surgeons.

Principles of Public Health Administration, 4th Ed.

By John J. Hanlon, M.S., M.D., M.P.H., 719 pp., $11.50, The C. V. Mosby Co., 1964.

FOURTH EDITION of a standard text. A "must" for those in the field; a "mustn't" for most others, of course.

The Biochemistry of Clinical Medicine, 3d Ed.

By William S. Hoffman, Ph.D., M.D., F.A.C.P., 802 pp., $12.50, Year Book Medical Publishers, Inc., 1963-1964.

THIRD EDITION in a decade. Attractively printed and bound, and not overwhelmingly large.

★Anesthesia for Infants and Children, 2d Ed.

By Robert M. Smith, M.D., 470 pp., $13.50, The C. V. Mosby Co., 1963.

THIS SECOND EDITION of an excellent text has nearly 200 illustrations, it is sound in content and beautiful in design and production.

Diagnostie Laboratory Hematology, 3d Ed.

By George E. Cartwright, M.D., 339 pp., $8.75, Grune & Stratton, 1963.

THIRD EDITION in nine years, with 15 new procedures added from Maxwell Wintrobe's department.

The Complications of Modern Medieal Praetiees

By David M. Spain, M.D., 342 pp., $12.75, Grune & Stratton, Inc., 1963.

IATROGENIC diseases and how to avoid producing them.

Progress in Neurology and Psyehiatry, Vol. 18

Edited by E. A. Spiegel, M.D., 695 pp., $14.75, Grune & Stratton, Inc., 1963.

SURELY, every neurologist and psychiatrist will want to own this. The editor is Professor of Experimental Neurology at Temple.

Handbook of Community Psyehiatry and Community Mental Health

Edited by Leopold Bellak, M.D., 465 pp., $14.50, Grune & Stratton, Inc., 1964.

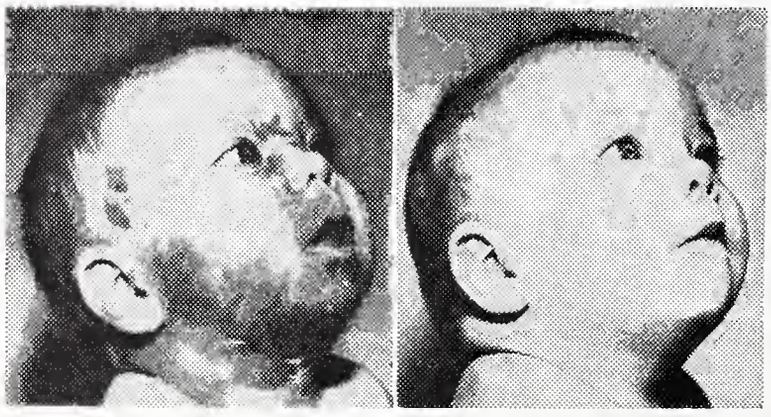
FAR MORE about this topic than most doctors can afford to know. For psychiatrists, and not all of them.

★Current Diagnosis & Treatment

By Henry Brainerd, M.D., and Sheldon Margen, M.D., 870 pp., $9.50, Lange Medical Publications, 1964.

A CONCISE summary of medicine as practiced at the University of California Medical Center in San Francisco. A bargain!

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Outline of Human Reproduction
By Ian Macgillivray, M.D., F.R.C.O.G., 100 pp., $2.50, Williams & Wilkins Co., 1963.

FOR STUDENT NURSES. Written in British style.

Pathogenesis of Leprosy (Ciba Foundation Study Group 15)
Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R., C.P., and Maeve O'Connor, B.A., 101 pp., $2.95, Little, Brown and Co., 1963.

INDISPENSABLE to leprologists; dispensable to others.

★An Atlas of Vascular Rings and Related Malformations of the Aortic Arch System
By James R. Stewart, M.D., M.S., Owings W. Kincaid, M.D., M.S., and Jesse E. Edwards, M.D., 171 pp., $10.75, Charles C. Thomas, 1963.

CARDIOLOGISTS and radiologists can hardly afford to be without this beautifully printed volume.

The Care of the Rheumatoid Hand
By Adrian E. Flatt, M.D., F.R.C.S., F.A.C.S., 222 pp., $11.50, The C. V. Mosby Company, 1963.

RUSSELL CECIL says this is "a most readable and informative book, full of useful practical knowledge." It certainly looks it!

★Medical Mycology
By Chester W. Emmons, Ph.D., Chapman H. Binford, A.B., M.D., and John P. Utz, M.D., 380 pp., $14.00, Lea & Febiger, 1963.

AN EXCELLENT and authoritative combination of reference text and laboratory manual.

continued page 316

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Book Reviews *continued from 315*

Progress in Gynecology, Vol. IV

By Joe V. Meigs, M.D., and Somers H. Sturgis, M.D., 676 pp., $16.75, Grune & Stratton, Inc., 1963.

THIRTY-EIGHT articles handsomely printed on slick paper.

Language for the Pre-school Deaf Child, 2d Ed.

By Grace M. Harris, 374 pp., $6.75, Grune & Stratton, Inc., 1963.

INVALUABLE, of course. Practical, and indispensable to those dealing with the problems.

The Chest Film in Massive Pulmonary Embolism

By Daniel J. Torrence, Jr., M.D., 74 pp., $6.75, Charles C. Thomas, 1963.

FOR RADIOLOGISTS and internists primarily. Very beautifully printed.

Elementary Medical Statistics, 2d Ed.

By Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., F.A.S.A., 381 pp., $9.00, W. B. Saunders Company, 1963.

SECOND EDITION of a leading standard text. Format is appealing—many questions and answers.

Occlusion of the Superior Mesenteric Artery

By Benjamin B. Jackson, M.D., F.A.C.S., 141 pp., $7.50, Charles C. Thomas, 1963.

EVERY GENERAL surgeon needs to know what's in this handsomely printed little volume. There are over 400 references in the bibliography.

Thrombophlebitis

By Roger M. Morrell, M.D., 182 pp., $6.50, Grune & Stratton, Inc., 1963.

REFERENCES to the literature for Chapter 1: 611; for Chapter 2, 145; Chapter 3, 200 (26 of them are numbered 45a through 45z!); Chapter 4, 42. Anticoagulants and thrombolysis are evaluated in detail. Irving Wright wrote the foreword.

Epidemiology & Communicable Disease Control

By Fred B. Rogers, M.S., M.D., M.P.H., F.A.C.P., 104 pp., $5.50, Grune & Stratton, Inc., 1963.

A COMMENDABLY concise compendium, pocket-size, for ready reference. Sound material, if in a somewhat inelegant dress as regards cover, paper, and type. ■

Hawaii Medical Association *continued from 297*

usual HMSA policy effective with his first day of employment.

The Treasurer requested that a policy be set relating to HMSA coverage for employees whose spouses' employers cover the entire family with HMSA insurance. Mr. Thorson advised that the BME policy was to transmit to HMSA the same amount for each employee, regardless of whether this produced double coverage. It was noted that even though the employee had double coverage in the HMSA, no additional benefits would accrue to the employee. The Treasurer recommended that when new employees are hired, that an investigation be made and

continued page 318

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Fusel oil	0.04%	0.10-0.25%
Acids	0.01%	0.01-0.10%
Esters	0.03%	0.01-0.13%
Aldehydes	trace	trace-0.03%
Formaldehyde	absent	absent
Furfural	absent	trace-0.01%
Alkaloids	absent	absent
Heavy Metals	absent	absent
Methyl Alcohol	absent	absent
Tannins	trace	0.02-0.07%
Odor on Evaporation	No disagreeable or irritating odor	Varies

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if it was determined that the employee is already covered by HMSA at no expense to the employee or the employee's spouse, that the employee receive the amount usually paid to HMSA.

ACTION:

It was voted to accept the Treasurer's recommendation and reimburse employees who are covered by HMSA through their sponses in the amount usually paid to HMSA.

It was voted to accept the Treasurer's Report in full.

REPORT OF STANDING COMMITTEES:

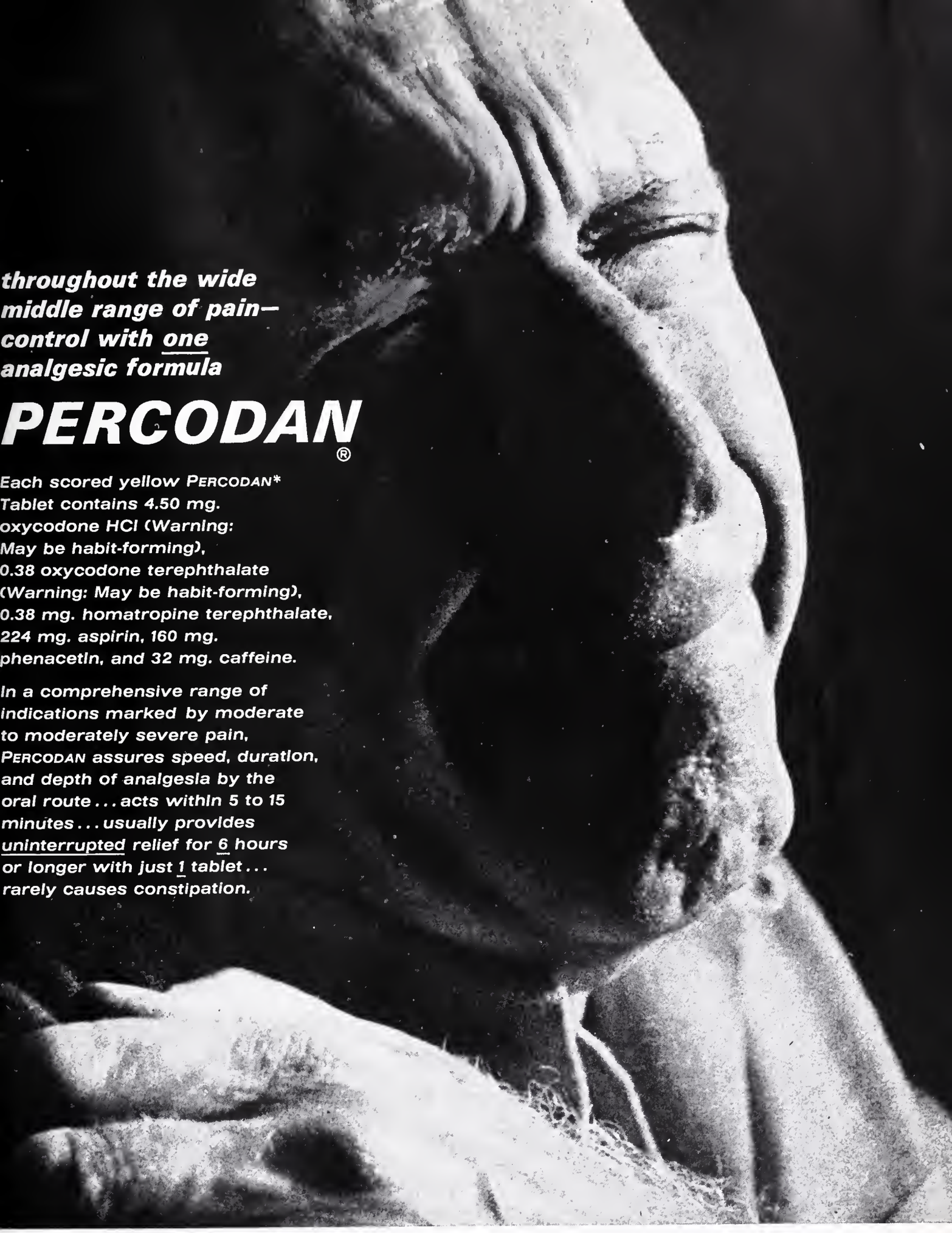
AMA Delegate's Report: Dr. Richard Moore gave the Council highlights on his report which had been circulated. He said that the word "constituent" has been changed to "state" and the word "session" changed to "convention." It was noted that the House approved a recommendation permitting the Speaker to convene the opening session of the House on Sunday afternoon or evening, rather than on Monday morning as is now the custom. He said a resolution was introduced by the Rhode Island delegation which asked for action against those component or constituent associations that deny membership to any qualified physician because of race, religion, or place of national origin. He informed the Council about a resolution introduced by the Pennsylvania delegation in relation to Kerr-Mills. Dr. Moore stated that the word aging be substituted for aged which is purely semantics. Dr. Moore said that in the opening session, various states stand up and present checks to the AMA-ERF. He noted that California donated $209,000, Utah contributed $13,000. Hawaii looked very sad in comparison. Dr. Moore was advised that doctors in Hawaii contribute individually rather than as an association. It was noted that the Woman's Auxiliary stands high with AMA-ERF.

ACTION:

It was voted to accept the AMA Delegate's report.

Arrangements: The Council was advised that the HCMS Woman's Auxiliary would like to take charge of the whole banquet during the Annual Meeting. A request was received from Mrs. Edwin Young which reads as follows: "Every year the HMA has a dinner at the Country Club and the tickets are about $8.00 a person. The HCMS Auxiliary came up with the idea that instead of the annual banquet the Auxiliary, with the HMA consent, will give their AMA-ERF dinner-dance-fashion show, which tentatively will be held at the Princess Kaiulani Hotel on May 2. They propose to charge something like $6.50 a person, excluding beverages. This includes an orchestra for dancing. Carol Yap has gone ahead with the fashion show and Liberty House has consented to let the Auxiliary use its own models which will be Auxiliary members. They want some of the doctors to model too. It will be something like the 1960 dinner dance which they had at the PK. The reason why they want to combine is first of all there is going to be a dinner anyway and so why not tie it together, and second, they will be getting so much more for less money even though it does not include the drinks. Third, they also feel that since it is tied in with the convention, the men will back them up and they will have an easier time to sell tickets. Over 600 people attended the 1960 fete. Nondoctor friends were brought as guests, i.e. K. S. Tom has a table of 20. It was noted that previously the banquet has not drawn a large group of doctors. Last year only 175 doctors and their wives attended. It was noted that receipts will go to the AMA-ERF. There was much discussion about either dropping the annual meeting banquet altogether and accept the Woman's Auxiliary request or simply having the doctors' banquet alone. It was felt that this should not be combined.

continued page 320



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Hawaii Medical Association *continued from 318*

ACTION:

It was voted to give the program suggested by the Woman's Auxiliary a trial run this year and substitute an AMA-ERF benefit party for the doctors' Annual Meeting banquet.

It was voted to purchase tickets for guest speakers and their wives to attend the AMA-ERF dinner-dance fashion show.

It was suggested that details be worked out by the Arrangements Committee.

Federal Medical Services: It was noted that the present contract with ODMC expires June 30, 1964. ODMC has requested our extension to August 31, the usual expiration date.

ACTION:

It was voted to give the President of HMA the right to extend the ODMC contract to August 31, 1964.

The Audiology Clinic at the University of Hawaii and its use by the VA was discussed. Dr. Pinkerton stated that diagnoses at the Audiology Clinic are made by Ph.D.'s. Some tests, such as the galvanic skin test, are available only at the University.

ACTION:

It was recommended to invite Mr. Toland of VA to the next Federal Medical Services Committee and present Dr. Pinkerton's position relative to referral of patients to the University.

Reports of the Careers, Disaster, and Chronic Illness & Aging Committees were noted.

Heart: It was noted that the Heart Committee will be meeting early in February to make a decision on whether they should amend the policy of not letting the film "Pulse of Life" be shown unless a physician is in attendance. This committee will also preview a film entitled "Coronary Arteriography."

ACTION:

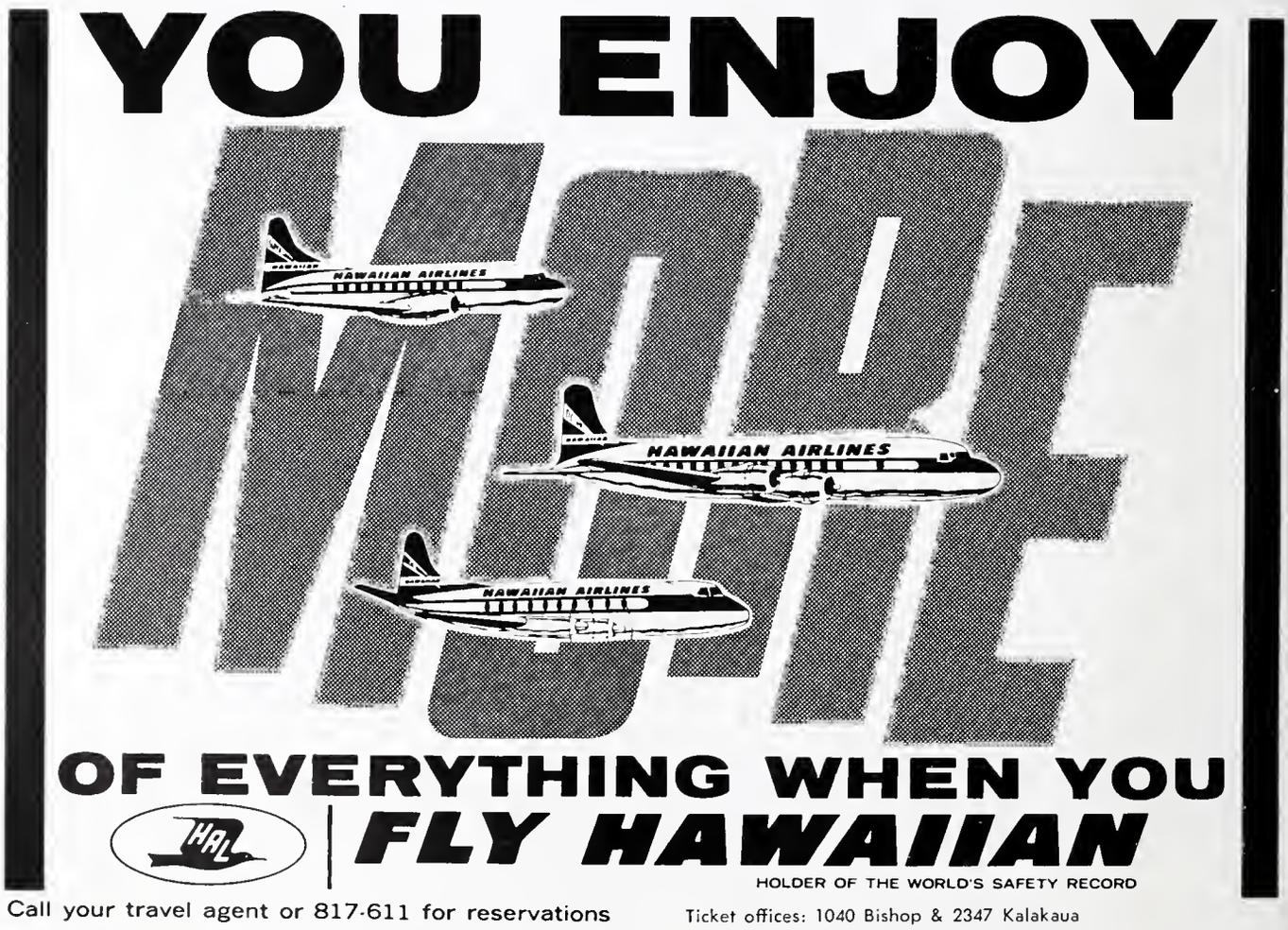
It was voted not to take action on whether a physician must be present at each showing of the "Pulse of Life" film until a final report is received from the Heart Committee.

Legislative: Dr. Chalmers reported that the Legislative Committee will have weekly meetings until the session is over. He informed the Council that Mr. Edwin Honda has accepted the terms of HMA and will act as counsel for the year. Dr. Chalmers stated that actions the Legislative Committee has taken include: (1) the usual dinner with Legislators. (2) Picking up the tab for the Kauai Medical Societies' dinner with Legislators. (3) Committee members agreed to have a representative from the Woman's Auxiliary sit in at the meetings so they would be better informed of what is going on. (4) Support Dr. Bernstein's proposal to issue temporary licenses to physicians in medical shortage areas.

Dr. Allison suggested that each member of the Council be put on the Legislative Committee's mailing list so that they will receive minutes and be kept better informed on what is going on in that committee.

Maternal and Perinatal Study Committee: Dr. Chinn advised he had heard some criticism of the committee's handling of report of a case on a neighbor island. It was noted that Dr. West had written a letter to the doctor involved. He said that the doctor had identified himself. The protocol used on that island is the same as used in Honolulu. Dr. Chinn did not feel that lay people should

continued page 322





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be present at these meetings. He was advised that these two lay people, one a recording secretary and the other an anesthesiologist, were invited to attend because they had been working with the case. Dr. Wade stated that he knows of four doctors who felt this was an improper procedure.

Medical Education: Dr. Mamiya reported to the Council the action that the Medical Education Committee took relative to the proposed Biomedical Science program. Dr. Mamiya stated some of the reasons for their decision: (1) Biomedical Science program at the University will upgrade the University. (2) This may develop new industries (industries which would concentrate around the University). (3) This Biomedical program can offer services to the State. Dr. Mamiya said that the development of this program may establish the University as a base for biomedical scientists. He also said that this program can be a stimulus to the postgraduate medical educational program. Dr. Mamiya stated that the committee also studied the cons, in particular the cost. Dr. Mamiya said if community clinical facilities are not available, the University will turn to Tripler. However, the University would like the support of the Medical Association. Dr. Miyamoto wanted to know if mainland medical schools will accept students from the two-year program. He was advised that there are anywhere from 300 to 900 openings in the third-year program now. It was noted that AAMC will probably accredit this Biomedical program.

Finances were discussed in detail. However, Dr. Mamiya said that his committee only approved support to this program in principle. It is up to the Legislature and the University to make the fiscal recommendations. Some felt there was more financial need for improvement of education in the lower grades.

Dr. Mamiya said that the University will send a representative to neighbor islands to present this program if the neighbor islands are interested.

Dr. Mamiya read the Medical Education Committee's action taken on this program as follows: "The Committee would strongly favor an extension of the present Biological Sciences at the University of Hawaii to include a Biomedical Science program provided that it is properly staffed and with sufficient funds to carry out a program of excellence."

Dr. Mamiya was asked if the University gave any hints as to whether or not they were thinking of a four-year school. He was advised that they have stated they are not planning to expand to a four-year school. Dr. Tschirgi's report says there should not be a four-year school. Dr. Tschirgi does not recommend encouraging students from the South Pacific and Asia to enroll in this program. It was noted that there should be a population of one million people in order to support a four-year school. Dr. Pinkerton said that a four-year school is the goal of every University. He also said if we approve the principle of the program, we are approving the concept of the idea. He questioned the ability to finance a medical school. He was advised that the Legislature will have to decide if the State can afford such a program. It was stated that at the present time we do not know if this program will bring in money or will cost us money.

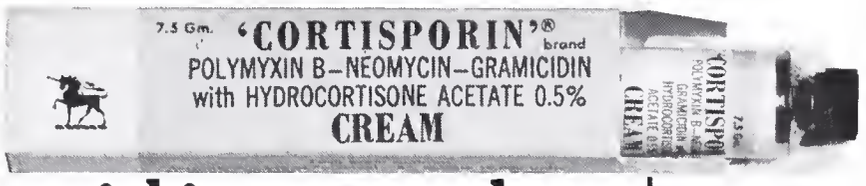
Dr. Giles suggested that the Public Relations man of the HMA make a statement for public release from what has been discussed at the Council meeting. It was noted that this would be a good news item. It was suggested to have the Public Relations subcommittee prepare something for release.

ACTION:

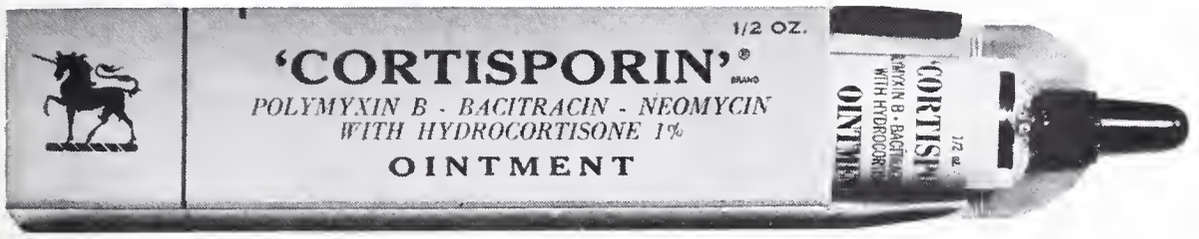
It was voted to approve the Medical Education Committee's resolution and include the committee's three points: (1) that this is a two-year program; (2) that the expenses for other areas of education should also be upgraded; and (3) that we approve the report on the principle that this program will be one of excellence.

continued page 324

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Hawaii Medical Association *continued from 322*

It was noted that the neighbor islands, except Kauai, are interested in having a representative from the University present the program.

Public Relations: Dr. Ivy presented his report. He felt it would be worthwhile to publish more Kerr-Mills flyers for the monthly Message of the Month. It was noted that it will cost about $750 for 60,000 more messages.

ACTION:

It was voted to authorize, in view of the fact that the Public Relations Committee has been very economical, to publish more Kerr-Mills flyers provided they stay within their budget.

UNFINISHED BUSINESS:

Nursing Home Survey: Drs. Bernstein and Lummis were present to explain the Nursing Home survey. He stated that this was brought up before the Chronic Illness & Aging Committee, which gave their approval. He said that the HCMS felt that regardless of what HMA said they would like to take it up independently. Dr. Bernstein said it was impractical for the department to have to report to five different societies.

Dr. Lummis gave a summary of the proposed nursing home registry. In June, 1963, there was a joint meeting and they came up with a proposed form. This form was then presented to the nursing home supervisors, the Chronic Illness & Aging Committee of the HMA, and to the Board of Governors of the HCMS. Reporting on this form is entirely voluntary. Dr. West asked what changes had been made from the original form and he was advised that the recording of the patient's name and the doctor who referred the patient was eliminated. Dr. Lummis was asked if the facilities involved had agreed to do this and he said that they were all agreeable.

Dr. Bernstein stated that some time ago there was a big spread in the newspapers about various nursing homes. This was poor public relations. He said that several doctors voluntarily went into the homes to examine the patients but to date these reports had not been received.

Dr. Lummis was asked who would be responsible for filling out a three-page form such as this. The Council was advised that the form could be filled out by nursing home personnel. Some help would have to come from the doctors. Dr. Lummis stated that the personnel would be working with the patients every day and would be capable of filling out most of the questions listed on the form. Doctors would only have to fill in pertinent information such as diagnosis, treatment, etc.

ACTION:

It was voted to approve the Nursing Home Survey form.

Publication of Minutes: The results of the post card survey were noted. The chair ruled that it had already been decided to continue to publish association proceedings.

NEW BUSINESS:

Appointment of HAMPAC Board:

ACTION:

It was voted to elect the following to the HAMPAC Board: James Matayoshi, Chisato Hayashi, R. J. McArthur, P. H. Liljestrand, B. A. Richardson, George Goto, John Chalmers, John C. Carson, Mauriee de Harne, P. M. Cockett, Mrs. Donald Jones.

continued page 326

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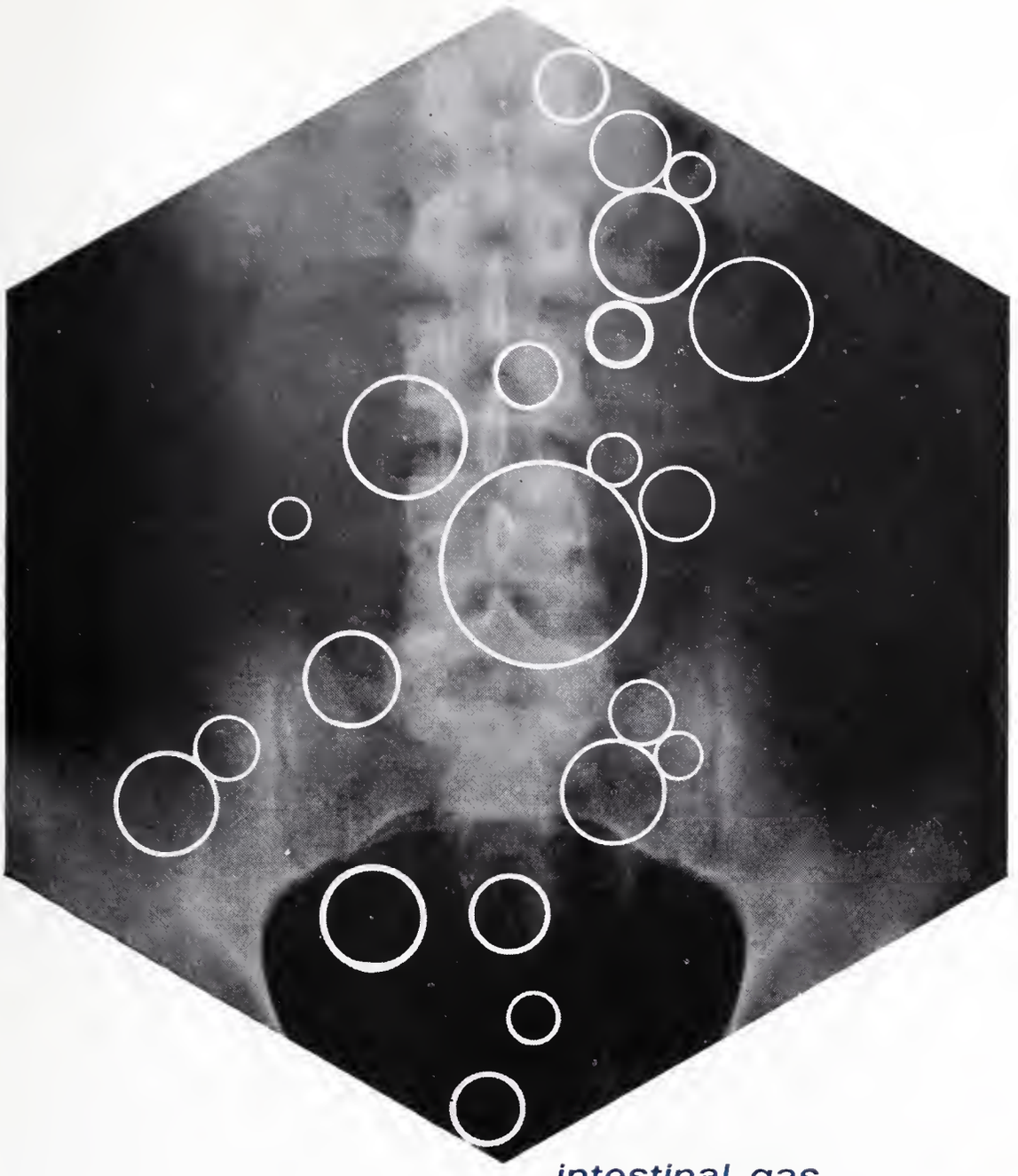
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Hawaii Medical Association *continued from 324*

Pharmacy: Dr. Bernstein stated that he promised Senator Vincent Yano he would send a consultant in to the hospitals to investigate the pharmacy set-up. Dr. D. Palmer was asked to do this. Dr. Palmer is not employed by the Health Deartment. Dr. Palmer was asked to go through the whole hospital thoroughly, including the nursing stations. Dr. Bernstein stated that help is needed from the doctors to improve the pharmacy set-up and the dispensing of drugs to patients. The Attorney General is going to give an opinion on hospital pharmacies. Dr. Bernstein said that Dr. Palmer should be commended for the very fine and detailed report he submitted to the Health Department. Dr. Lummis condensed Dr. Palmer's report for presentation to the Council. The report included the following findings: 1. Personnel: Where there are pharmacists in the hospital, they seem to get along quite well. Dr. Palmer recommended in his report that the hospitals without pharmacists employ a consultant. It was also noted that the good quality of the program during the day does not follow into the night hours.

Dr. Bernstein said that if the doctors do not see that the pharmacies are run properly, the pharmacists will step in and take over. 2. Labels: (a) labels should be typed or printed; and (b) it was found that often the pharmacists are unable to read the labels. 3. Biologicals: perishable drugs are not always refrigerated. 3. Outdated drugs: out-dated drugs are sometimes in stock. 4. Compounding drugs: Dr. Palmer noted that he saw personnel other than the pharmacists compounding drugs. Dr. Bernstein stated that under the regulation no one but a pharmacist should do the compounding. 5. Nursing stations are often cluttered with out-dated drugs, poisons, aspirin, etc. 6. After hours, less competent people are dispensing drugs. 7. Drugs are sometimes given to employees without a doctor's prescription. Dr. Palmer did state in his report that in cases where a pharmacist is not available, a qualified Registered Nurse could dispense drugs but that an LPN or someone other than a RN should not be doing this. The Health Department licenses hospital pharmacies and the Board of Pharmacy licenses retail pharmacies.

Dr. Bernstein said that the doctors should take a hard look at what is going on in the hospitals. He suggested that the doctors could develop some kind of guide to be distributed to the various hospitals. He also said that he would like to report back to Senator Yano that the Hospital Board and the Hawaii Medical Association will do something about this. Dr. Bernstein said that periodically he will ask Dr. Palmer to take a look at the situation. Dr. Bernstein stated that if the rural areas are unable to get a pharmacist, then some qualified person should do the prepackaging and labeling of drugs. It was felt that something like this could be done. It was suggested that a copy of Dr. Palmer's report be sent to each hospital for their comments. It was also suggested that the HMA form a committee now instead of waiting until March when the AMA has a meeting with the Pharmacy and Therapeutics Associations. This committee should follow up to see if changes should be recommended.

ACTION:

It was voted to authorize the President to appoint an ad hoc committee to work with the Department of Health and have their report come back to the Council. The Department of Health's report was accepted in principle.

Council and Scientific Meetings on Neighbor Islands: Dr. Allison felt this is a good idea. It was suggested to have the Scientific Program Committee start making plans for the 1965 meeting.

continued page 328



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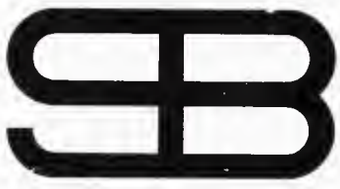
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Hawaii Medical Association *continued from 326*

ACTION:

It was voted to have dates set and arrangements for spaee made for the annual meeting in 1965.

It was voted to make plans for a Counеil meeting to be held on one of the neighbor islands.

It was noted that Kauai is not interested in having meetings scheduled on their island.

Introduction of AMA Representative: Mr. Pompelli, Field Representative of the American Medical Association was introduced to the Council. Mr. Pompelli stated that his role with the AMA is to act as liaison between medical associations of the Western states and AMA. He stated that his trip to Hawaii this time is strictly a "get-acquainted" trip.

Mr. Pompelli was asked why HMA was not informed by AMA that a representative was in Honolulu regarding the University of Hawaii proposed biomedical science program. Mr. Pompelli said that, from what he gathered from communications, AMA representatives were officially invited with the approval of the HMA. It was noted that AMA representatives did not contact the HMA when they were in town. Mr. Pompelli said that he will get all communications and send them to HMA.

Mr. Pompelli invited doctors to attend the AMA Annual Convention which will be held in San Francisco on June 21-25, 1964. He said that this would be a "fantastic" affair. He urged the doctors to attend if they could possibly attend. He said that they could see how the House of Delegates operates. He said that the Scientific Program is really something to see. ■

RANDAL A. NISHIJIMA, M.D.
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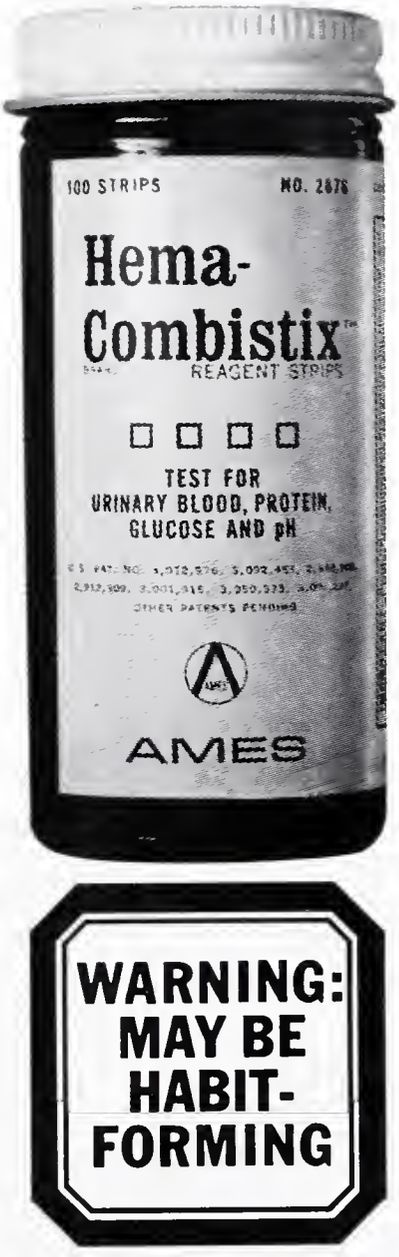
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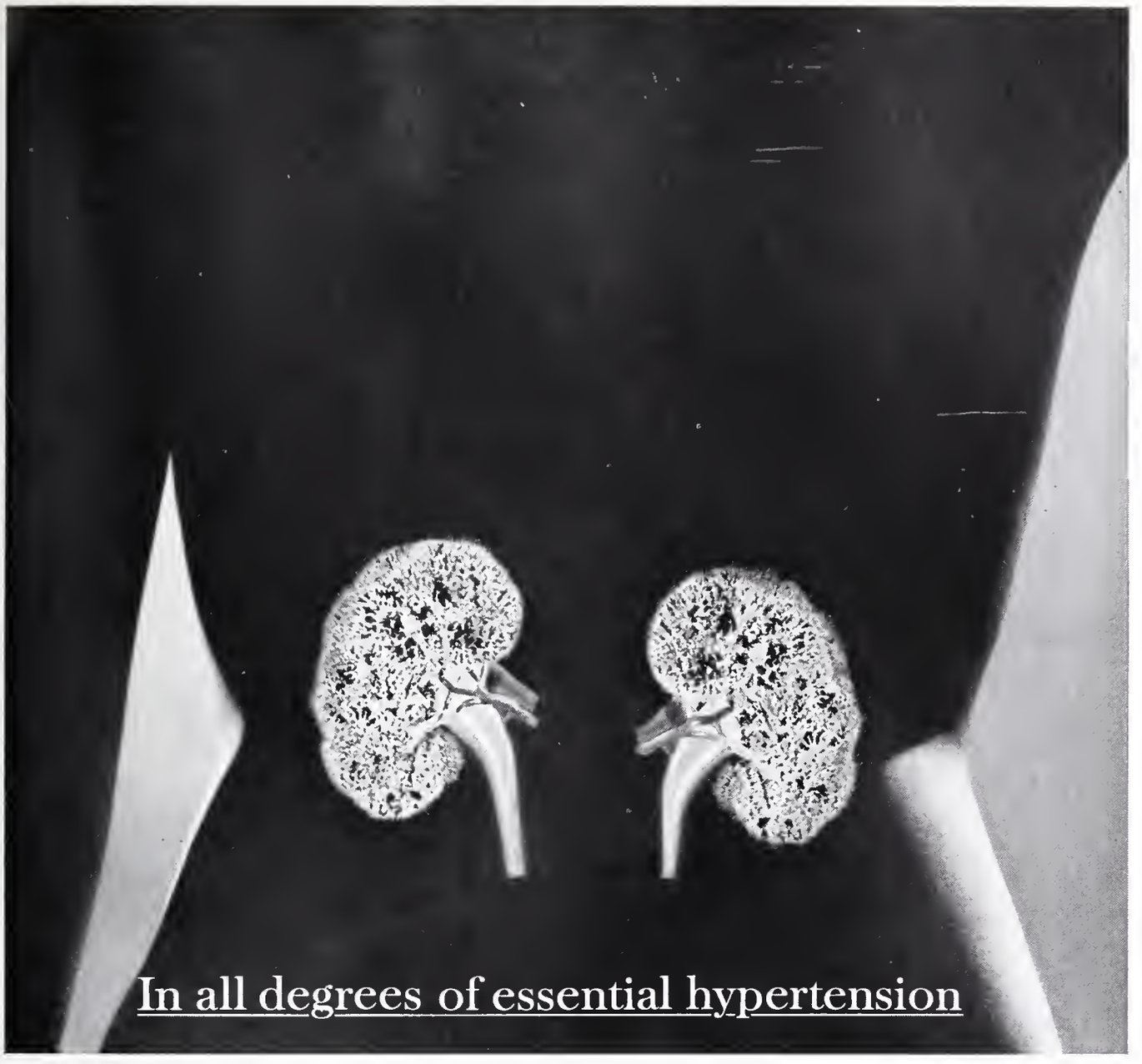
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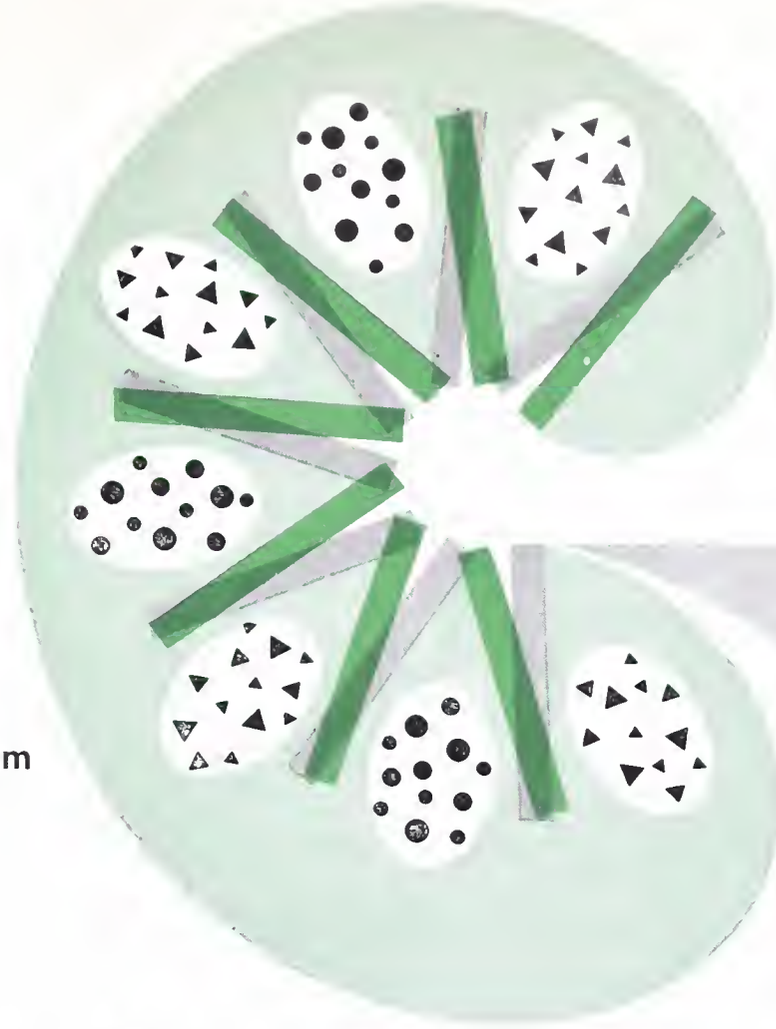
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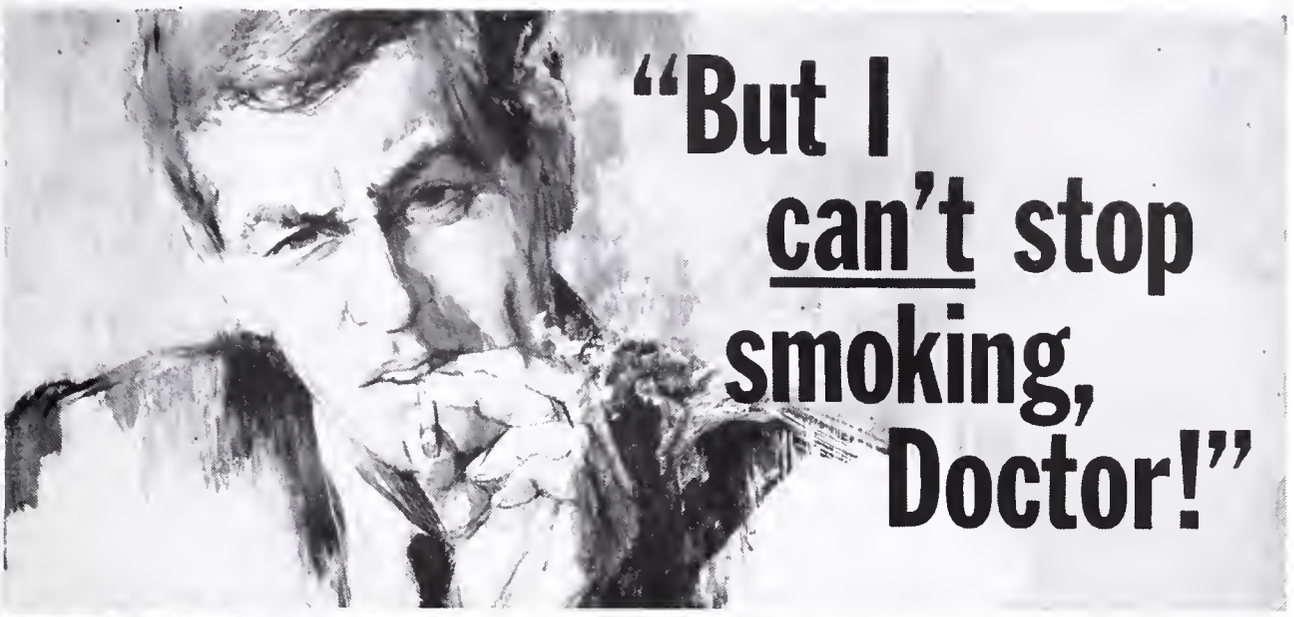
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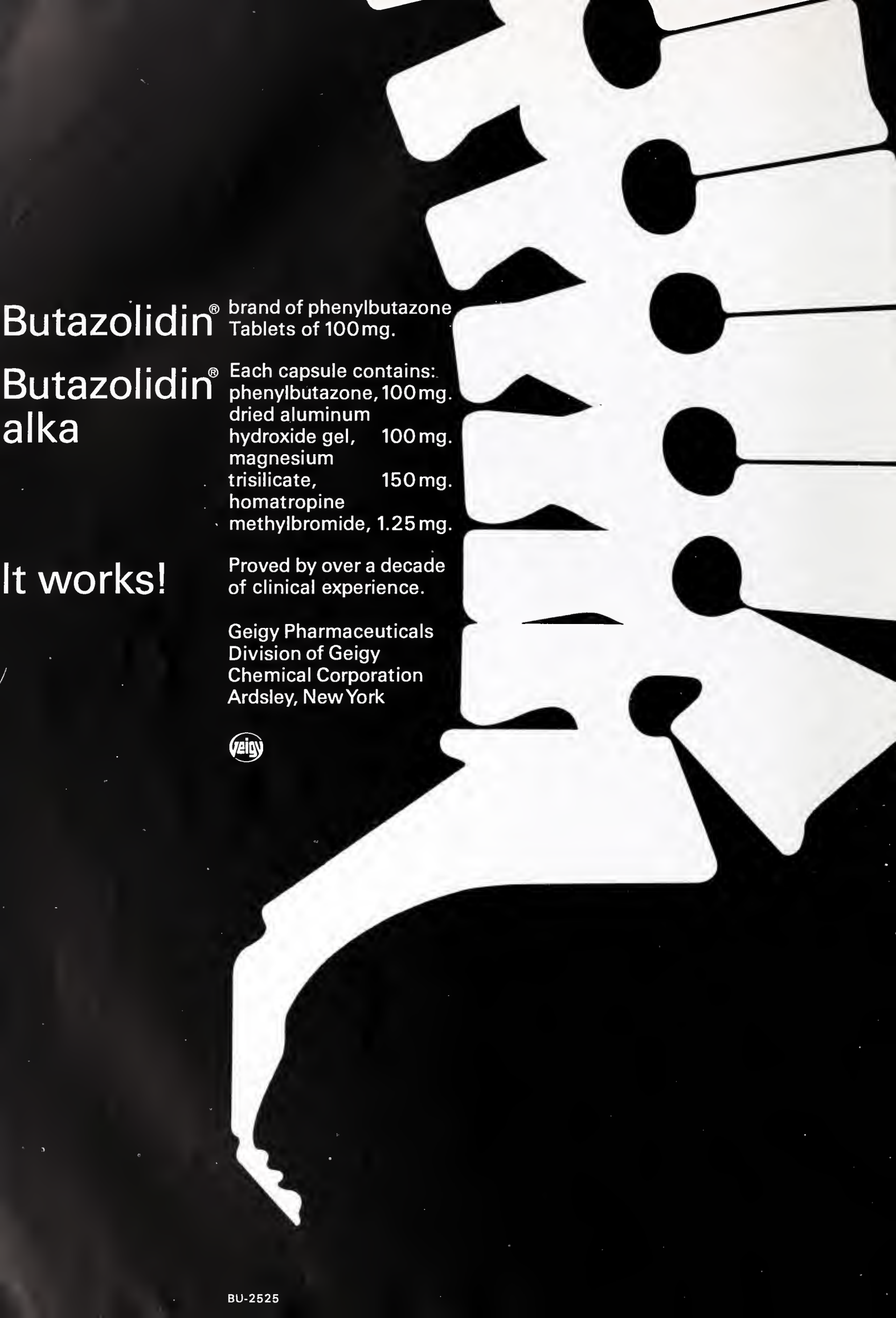
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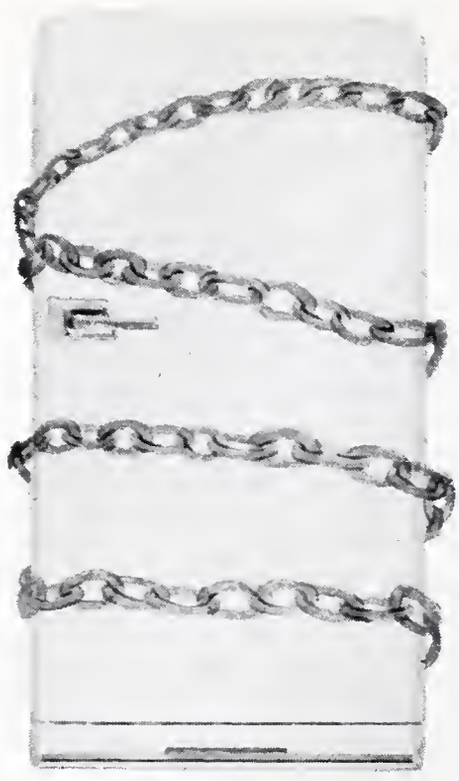
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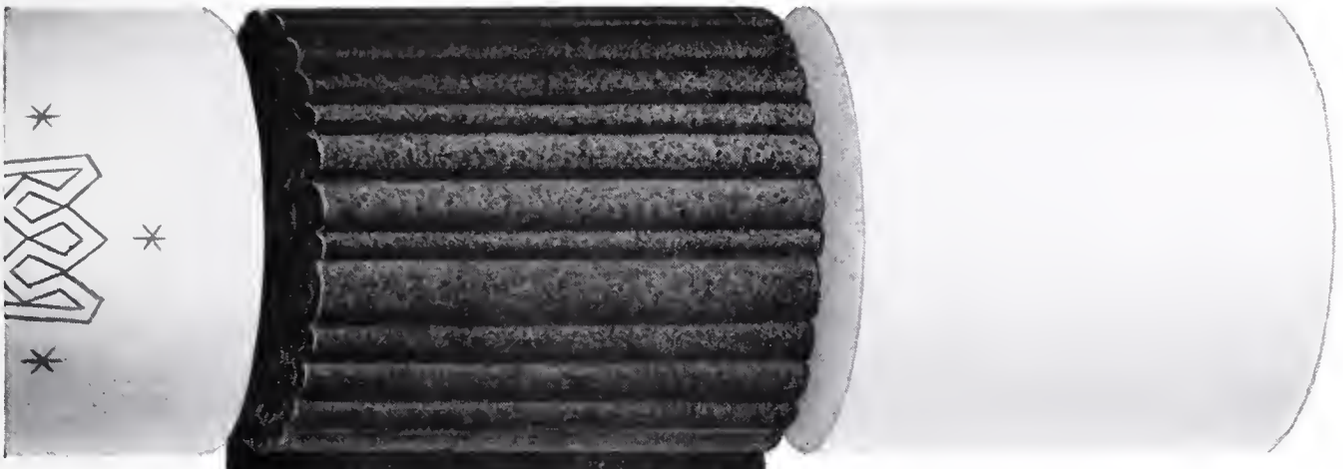
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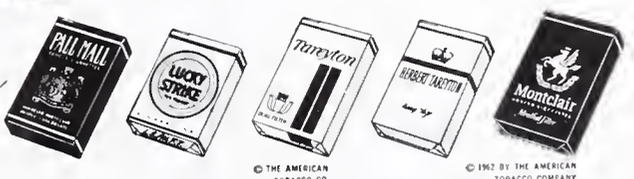
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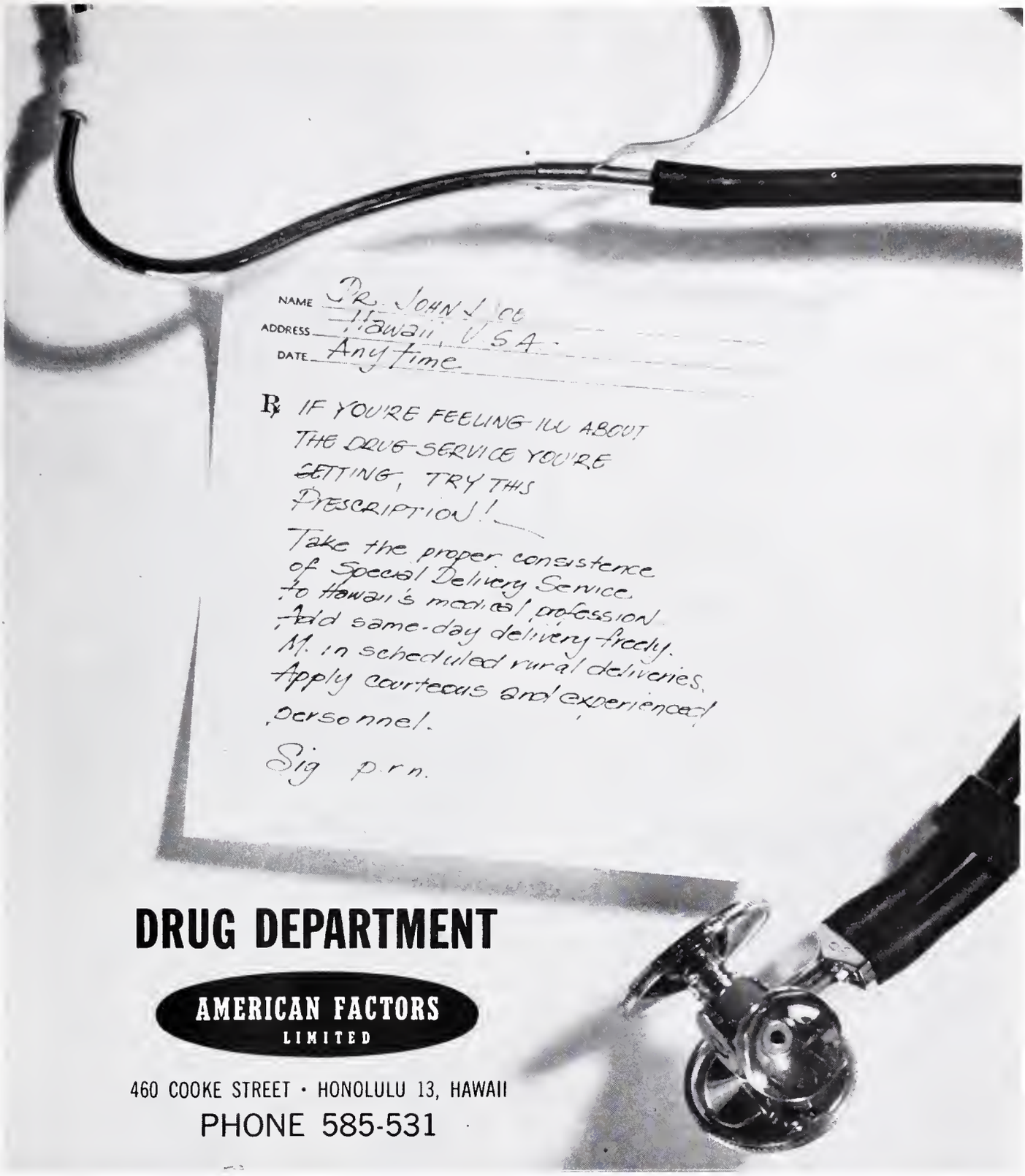
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What degree of reliance may be placed in the roentgen diagnosis of "benign" gastric ulcer? In Hawaii: about 85 per cent.

Accuracy of Roentgenographic Examination in the Differential Diagnosis of Gastric Ulcer

WILLIAM H. BACHRACH, M.D.,* *Los Angeles*

• *Review of roentgenograms and histologic diagnoses on 100 nearly consecutive cases of gastric ulcer, all operated upon, disclosed that of ten cancers in the series, only two were diagnosed (by the author) roentgenologically; one was called equivocal by x-ray, and seven were called benign. The proportion of "confined" carcinoma and of large craters was unusually high, and eight of the ten carcinomas were of the "superficial" variety. The author suggests roentgen re-examination after intensive medical therapy as an approach to reduction of this diagnostic error.*

STUDIES on gastric ulcer have led me to conclude, first, that a reliable diagnosis of benign ulcer can be made if the roentgenograms show a projecting crater with smooth margins and intact adjacent mucosa and, second, that complete disappearance of a crater following therapy is proof of benignancy. Exceptions to both these rules occur, but so rarely as to present no significant problem in the differential diagnosis. Accordingly, I concur in the prevailing medical policy of intensive medical therapy for all gastric ulcers except those which appear malignant by roentgenographic, gastroscopic or cytologic examination. Surgery is reserved for the infrequent case which does not go on to complete healing.

An equally energetic advocate of the view that ulcer is a surgical disease is J. E. Strode,[1–3] of Honolulu, who operates upon all patients with ulceration of the stomach as soon as possible after the roentgenographic demonstration of the ulcer.

These diametrically opposite views will necessarily persist until a reliable study can be carried out which will be acceptable to both the medical men and the surgeons. An important requirement of such a project is that the final diagnosis be established beyond question. Since many observers do not consider complete roentgenographic disappearance of the lesion as acceptable evidence of benignancy, the ideal study would embrace a consecutive series of patients operated upon after the necessary diagnostic observations were made. As a step in this direction, it occurred to me that a study of Strode's material might provide a test of the first premise stated above: namely, that a reliable diagnosis of benign ulcer can be made on the roentgen examination, not in all cases, but at least in those in which the crater projects, the ulcer margins are smooth and the adjacent mucosa is intact. Dr. Strode was so interested in this proposal that he not only gave me free access to all of the records of his gastric ulcer cases, but gave his personal assistance and that of his staff, and provided every convenience for the completion of

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Received for publication December 27, 1963.

the project, the results of which are reported herewith.

100 CASES REVIEWED

The files of all patients operated upon for an ulcerative lesion of the stomach were examined, working backward from the most recent case until 100 cases were accumulated in which the roentgenograms were available. Since the films could not be located for several of the original 100 patients, this is not strictly a consecutive series, but for all practical purposes it may be considered so.

The films were then read without knowledge of the original roentgenographic diagnosis and, of course, without knowledge of the findings of the surgeon or pathologist. A record was made of the number of films available for each patient and an opinion was recorded as to whether or not the examination could be considered technically adequate to portray the characteristics of the lesion. An attempt was made to interpret the roentgenograms on the basis of the three criteria already mentioned, namely, projection of the crater, smoothness of the ulcer margins and condition of the mucosa in the area of the ulcer.

DIAGNOSTIC CATEGORIES

The diagnoses were recorded as benign, equivocal, or malignant, according to the following definition:

Benign. Categorical diagnosis of benign ulcer, malignancy excluded. To permit this diagnosis, the crater had to be shown in full profile so that the condition of the ulcer margins and the relation of the crater to the gastric wall could be evaluated; also the mucosa had to be portrayed in adequate detail.

Equivocal. Categorical diagnosis not possible from the available films, malignancy not excluded but not probable. This diagnosis indicated that the basic criteria could not be interpreted with the views at hand, but that a mass lesion did not appear to be present.

Malignant. Probably or definitely malignant.

After the roentgenographic diagnoses were recorded for the 100 cases, the reports of operation and pathology were reviewed to ascertain the anatomic diagnoses.

CANCERS CALLED BENIGN

Since three of the patients appeared to have two ulcers, readings were made on 103 ulcers in the 100 cases (Table 1).

TABLE 1.—*X-ray Diagnosis vs. Final Diagnosis in 100 Cases (103 Ulcers).*

		FINAL DIAGNOSIS	
	X-RAY DIAGNOSIS	*Benign*	*Malignant*
Benign	47	40	7
Equivocal	38	37	1
Malignant	18	16	2

There were ten malignancies in the 100 cases, seven of which we diagnosed roentgenographically as benign, one as equivocal and two as malignant. Thus, of 47 cases in which a categorical diagnosis of benign ulcer was made, seven were malignant—an error of 15 per cent.

The details of the ten cases are shown in Table 2. Of the two which were grossly malignant, one patient (Case 9) had an obvious mass lesion of the stomach and esophagus roentgenologically. In the other patient (No. 6), the only available preoperative roentgenograms (Fig. 1) were made five months before the operation. We interpreted the examination as showing a crater, projecting out from the lesser curvature of the body of the stomach, measuring 35 mm in width and 25 mm in depth. In the only exposure (Fig. 1C) which shows this crater, the upper margin was not smooth; nevertheless, we read this as a benign ulcer because the mucosa adjacent to the crater appears intact. The appearance of Fig. 1A and especially of Fig. 1B is compatible with a filling defect of the distal stomach; however, these views do not appear to include the crater seen in Fig. 1C. The surgical report described "a large lesion involving the wall of the stomach with indurated infiltrated omentum and carcinomatous nodules all around the stomach and some in the liver." The stomach

TABLE 2.—*Analysis of Malignancies in 100 Cases of Gastric Ulcer.*

	NAME	AGE	AUTHOR'S INTERPRETATION	PATHOLOGY	INTERVAL FROM LAST X-RAY TO OPERATION
1	H.N.	74	Benign	AdenoCa adjacent to chronic G.U.	10 days
2	J.P.	77	Benign	AdenoCa invading into but not through muscle	10 days
3	M.A.	59	Benign	AdenoCa invading but not through m. mucosae	6 days
4	M.K.	75	Benign	AdenoCa not invading beyond sub-mucosa	3 days
5	S.T.	63	Benign	AdenoCa at edge of chronic G.U.	8 days
6	M.S.	39	Benign	Obvious disseminated cancer. No biopsy	145 days
7	M.N.	49	Benign	AdenoCa at edge of chronic G.U.	6 days
8	D.L.	48	Equivocal	AdenoCa invading muscle	38 days
9	J.H.	65	Malignant	AdenoCa of stomach invading esophagus	17 days
10	J.W.	35	Malignant	Superficial carcinoma in situ	11 days

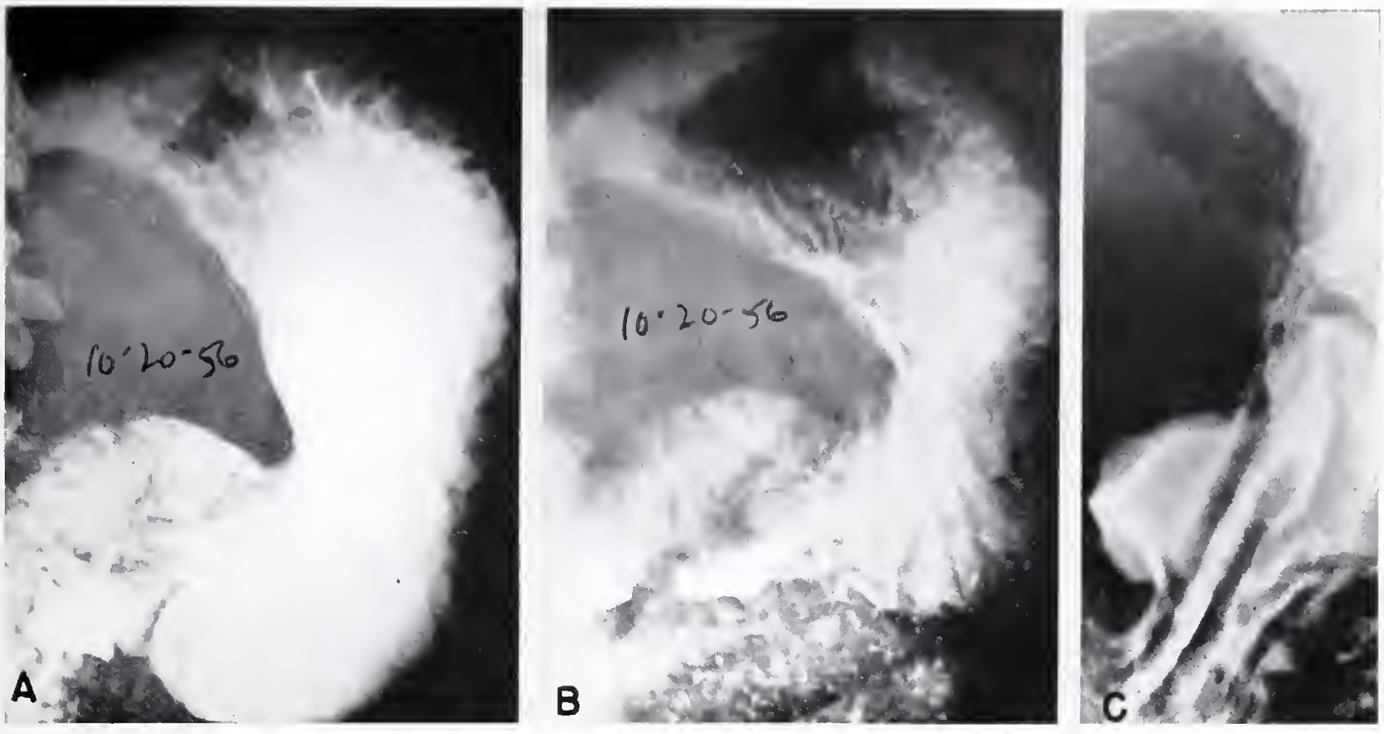


FIGURE 1.

was not opened nor a biopsy obtained. In all respects, this was not a satisfactory case because of the extremely limited material available. It is hard to believe that Fig. 1C is from the same series as Fig. 1A and 1B, but this was the way they were designated.

The remaining eight cases were reported by the pathologist as either superficial carcinoma or carcinoma in the edge of a chronic ulcer. Case 10 was diagnosed roentgenologically as malignant, for obvious reasons (Fig. 2). It is surprising, considering the roentgen appearance, that this was reported as superficial *in situ* carcinoma, but apparently the pathologist was using this in the sense of "carci-



FIGURE 2.

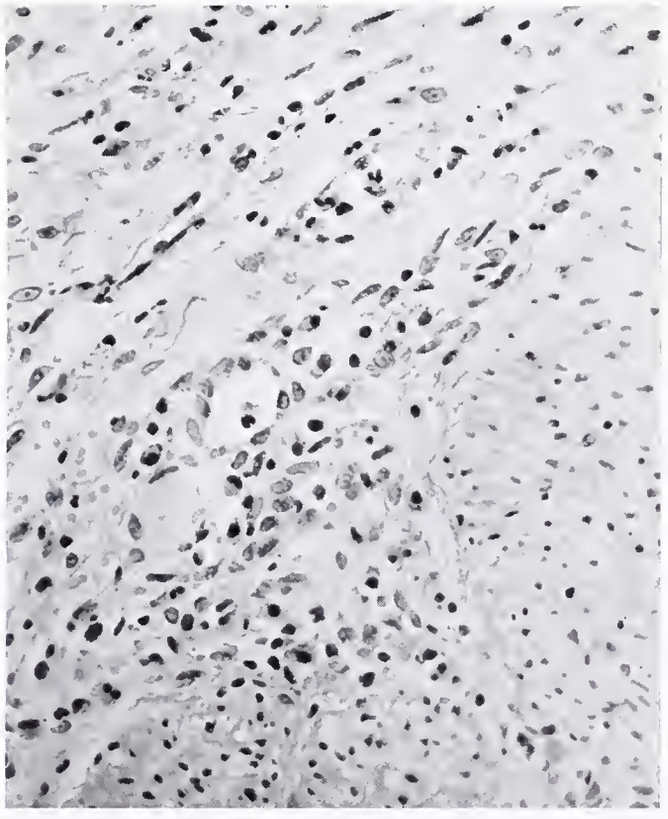


FIGURE 3.

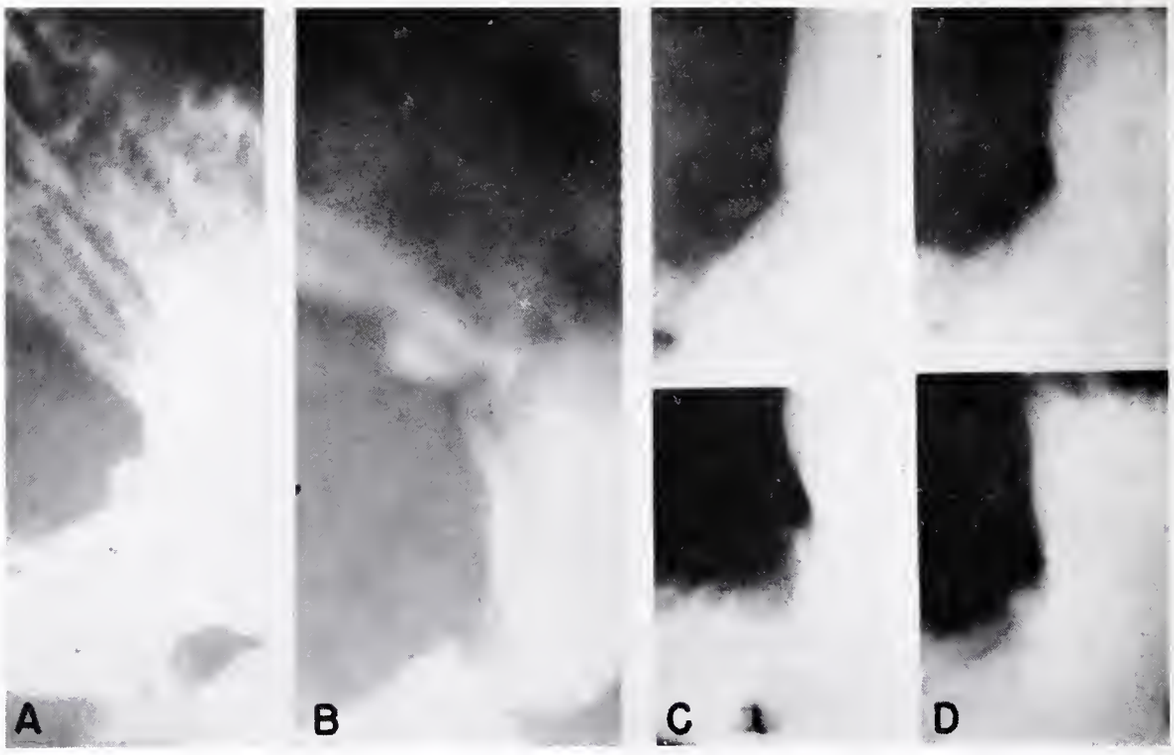


FIGURE 4.

noma not extending through the serosa," for certainly it extends into the muscularis (Fig. 3).

In Case 8, the roentgen diagnosis was equivocal; I could not actually identify a definite crater in the roentgenograms. The surgeon reported "an indurated area in the lesser curvature of the stomach not too far from the pylorus." The pathologist described "an ulcerated area on the lesser curvature 5 cm from the distal line of resection, measuring 1 cm in diameter and 2 mm in depth, with a gray, hemorrhagic, necrotic base. The wall is not thickened or eroded in this area. However there is an irregular, superficial ulceration extending from this area along the anterior wall. The mucosal surface is depressed and flattened in this area. The wall is firm. The broadest dimension is 5 cm." Microscopic sections "through the bed of the chronic ulcer reveals a necrotic surface with acute and chronic inflammation, attempted granulation, and fibrosis. Closer examination, however, reveals tumor cells diffusely scattered in this area extending into the wall primarily between bundles of smooth muscle." The diagnosis was "anaplastic carcinoma with focal penetration of wall and superficial spread." Obviously, the roentgenographic, the gross anatomic, and the microscopic descriptions are difficult to correlate in this case.

The remaining six cases of superficial carcinoma, or carcinoma at the edge of a chronic ulcer, were interpreted roentgenologically as benign; all of these cases presented problems in interpretation, an in retrospect only one satisfied the prescribed criteria for benignancy.

The roentgenograms in Case 1 are reproduced in Fig. 4. Mucosal detail is lacking, and the quality of the roentgenograms is not adequate to evaluate the ulcer margins. In Fig. 4B, the crater is seen in profile and it appears not only to project beyond

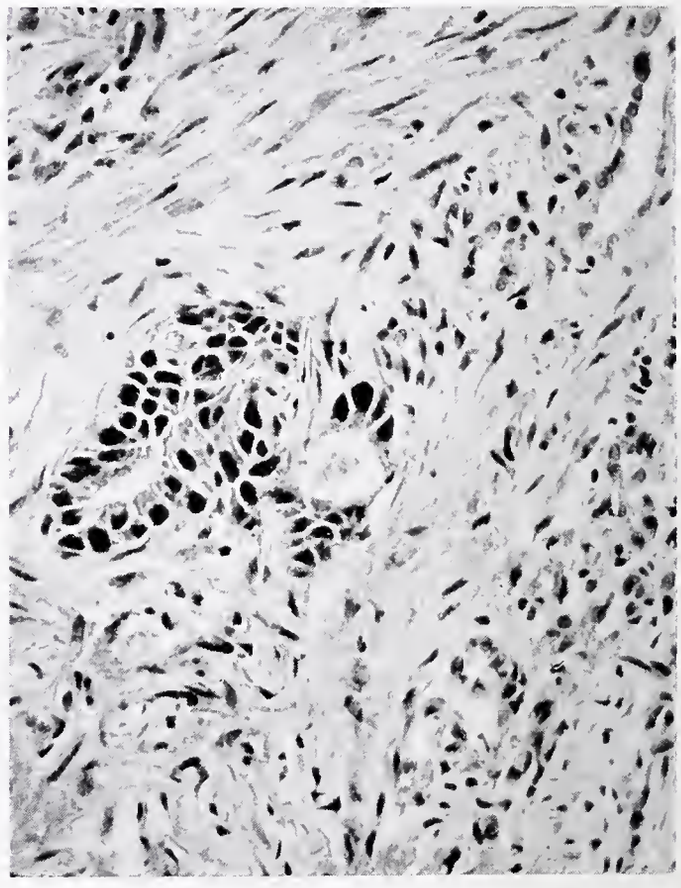


FIGURE 5.

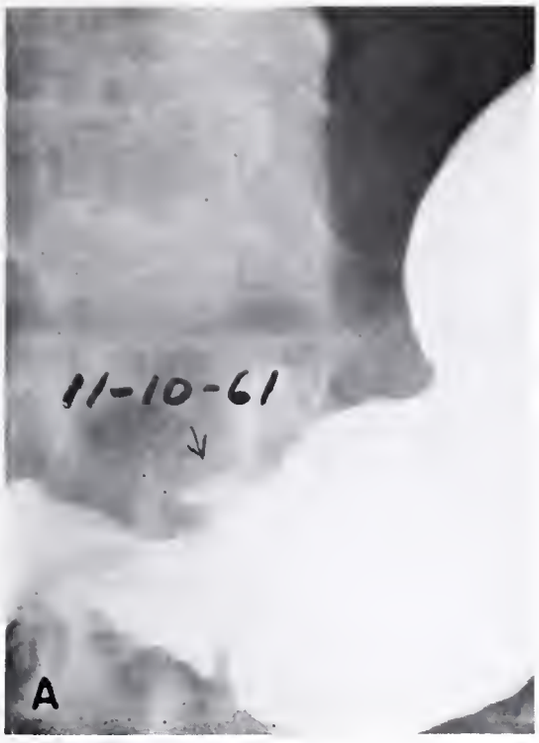


FIGURE 6.

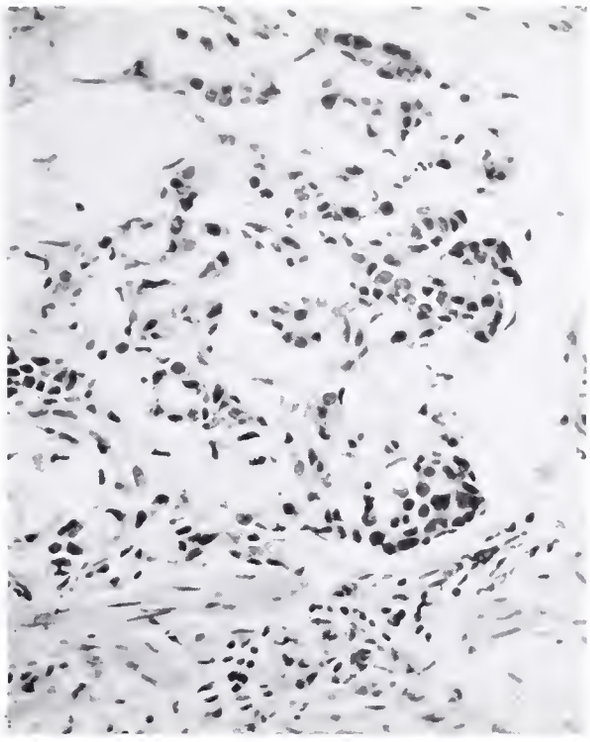


FIGURE 7.

the border of the lesser curvature but also to show a radiolucent zone suggestive of an "ulcer collar." On the other hand, the same view is suggestive of a filling defect just distal to the crater. In the resected specimen, the gross appearance was described as that of a chronic ulcer, while the microscopic sections were reported as showing adenocarcinoma adjacent to a chronic gastric ulcer (Fig. 5).

In Case 2, the problem is identical; in spite of what appears (Fig. 6) to be a projecting crater with a radiolucent collar, one can, in retrospect, make out a case for a filling defect within the lumen just distal to the niche. In this instance, the microscopic sections (Fig. 7) clearly showed invasive carcinoma.

The pathologic findings in Case 3 came as a complete surprise. Granted that the roentgenograms (Fig. 8) leave much to be desired, the projecting crater with smooth margins seen in Fig. 8B seemed sufficiently typical that the absence of mucosal detail did not deter me from making a confident diagnosis of benign ulcer. Judging from the cross-sectional view of the ulcer (Fig. 9), mucosal relief studies would theoretically have shown no significant roentgenological alteration of the mucosa, yet this is histologically proven adenocarcinoma.

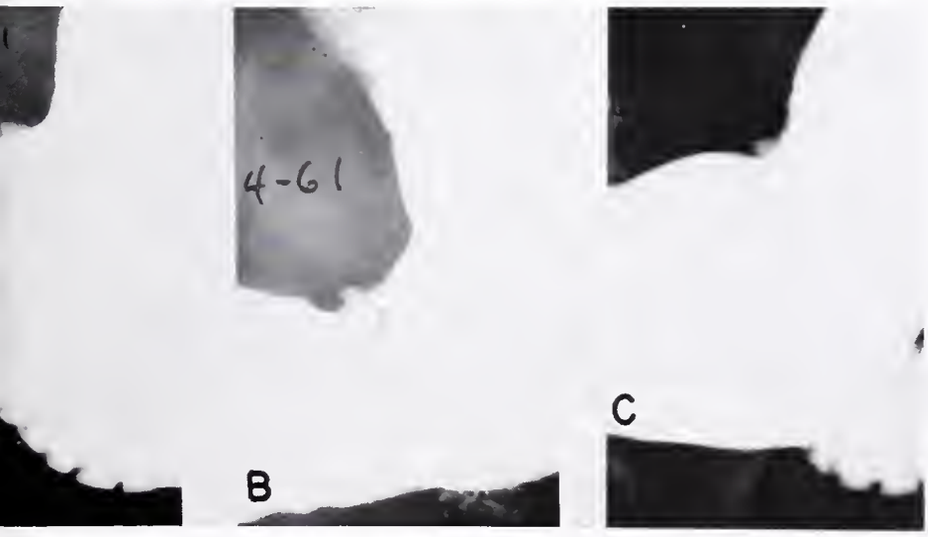


FIGURE 8.

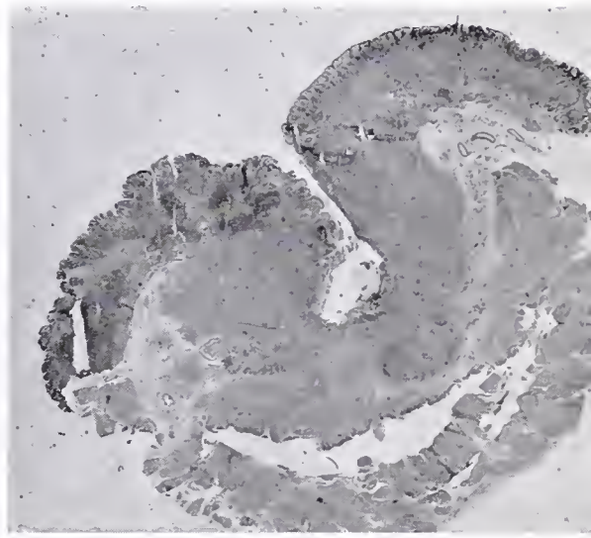


FIGURE 9.

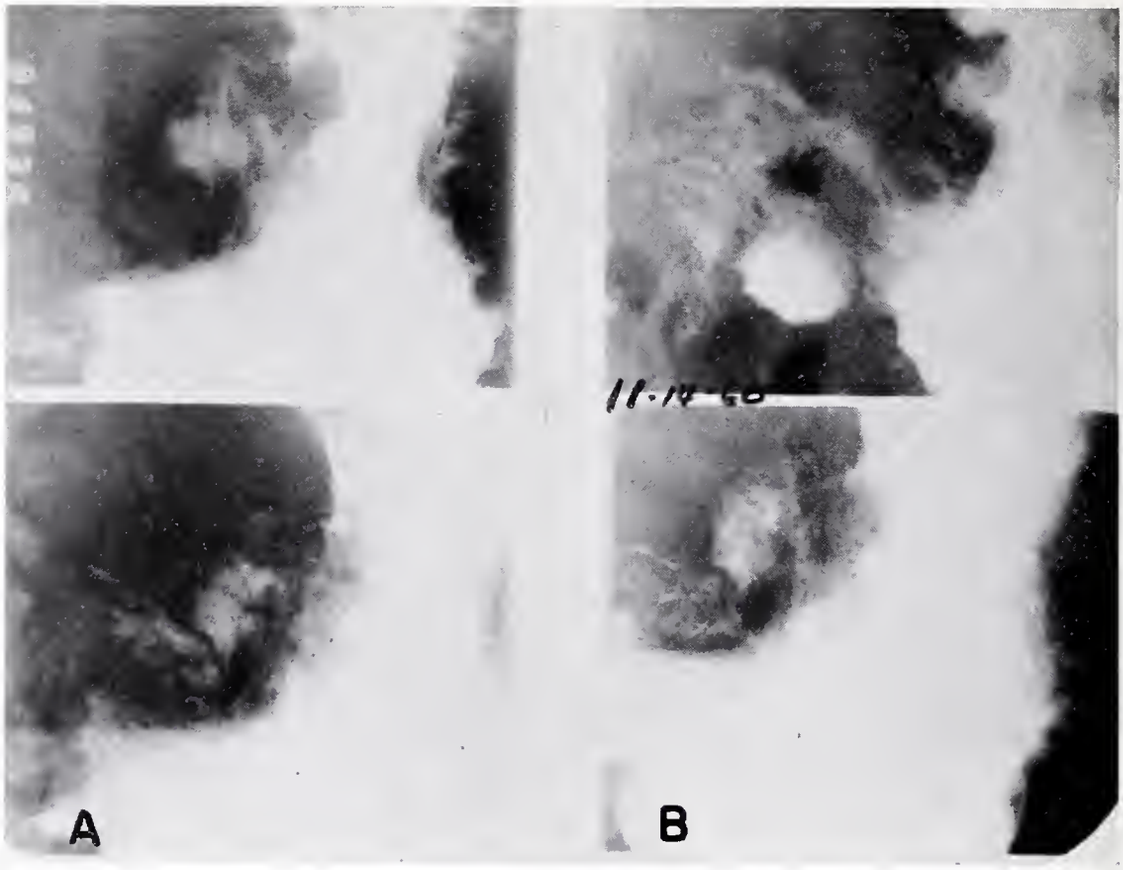


FIGURE 10.



FIGURE 11.

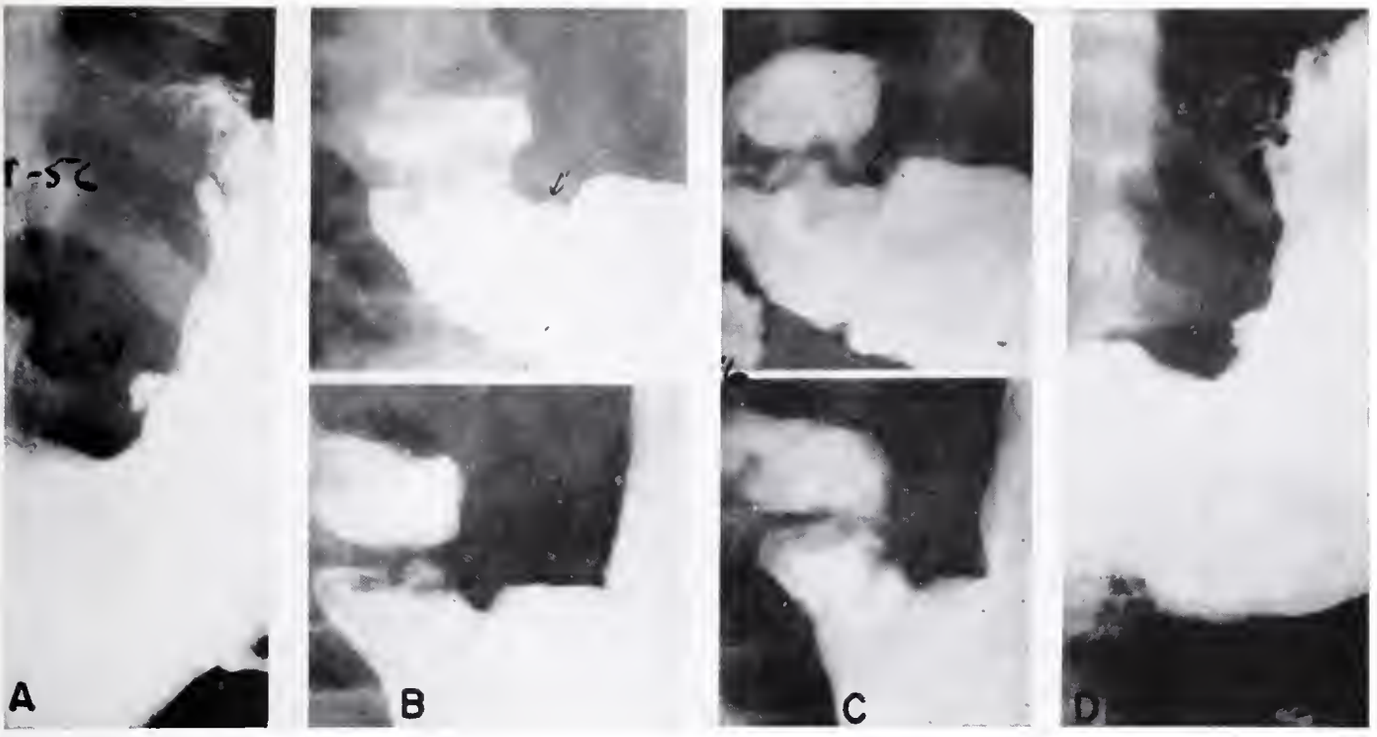


FIGURE 12.

In Case 5, all of the available roentgenographic views (Fig. 10) show a filling defect with obliteration of mucosal pattern in the area of the crater, and there is no excuse for calling this benign. The reason I did so was that I had not previously encountered a case of gastric carcinoma with so deep an external niche with overhanging margins. Now I have, as the microscopic appearance (Fig. 11) clearly shows. The pathological interpretation of record was adenocarcinoma at the edge of a chronic gastric ulcer. The same report was given in Case 7, in which the roentgenograms (Fig. 12) suggests two ulcers, one in the prepylorus and one on the lesser curvature of the body. The latter (Fig. 12A and 12D) was thought to be benign. The resected specimen was described as containing one ulcer, which by measurement seemed to correspond with that on the upper part of the stomach in the roentgenograms. Microscopically, it was unquestionably an actively growing carcinoma (Fig. 13).

Case 4, the best documented roentgenographically (Fig. 14 and 15), was thought to represent a typical benign ulcer by virtue of a projecting crater with smooth margins, a Hampton's line (Fig. 15D, lower view) and intact mucosa (Fig. 14B). The pathologist's report that the adenocarcinoma (Fig. 16) found at operation was superficial explains the difficulty in recognizing malignancy in the roentgenograms. In retrospect, more attention might perhaps have been paid to the suggested filling defect in the upper stomach proximal to the crater (Fig. 14C).

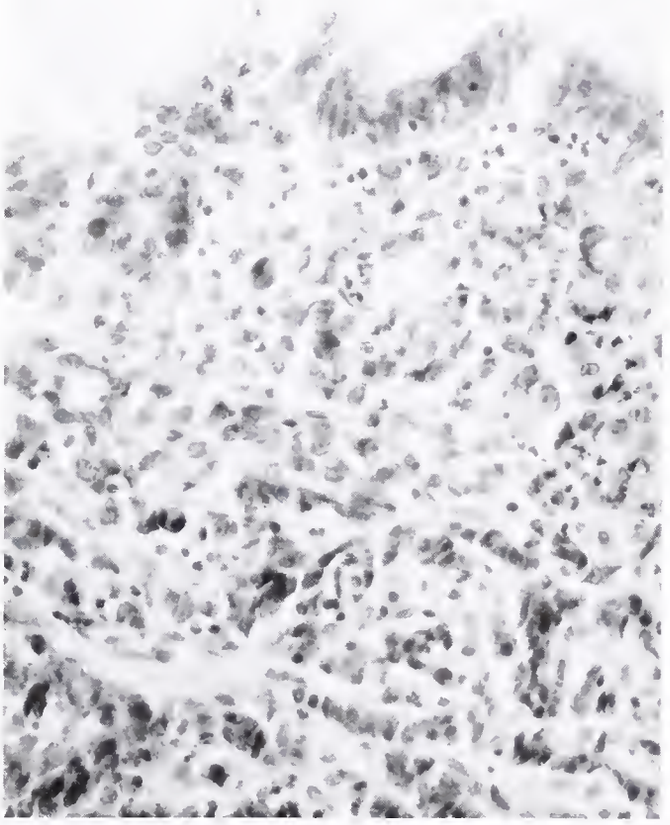


FIGURE 13.

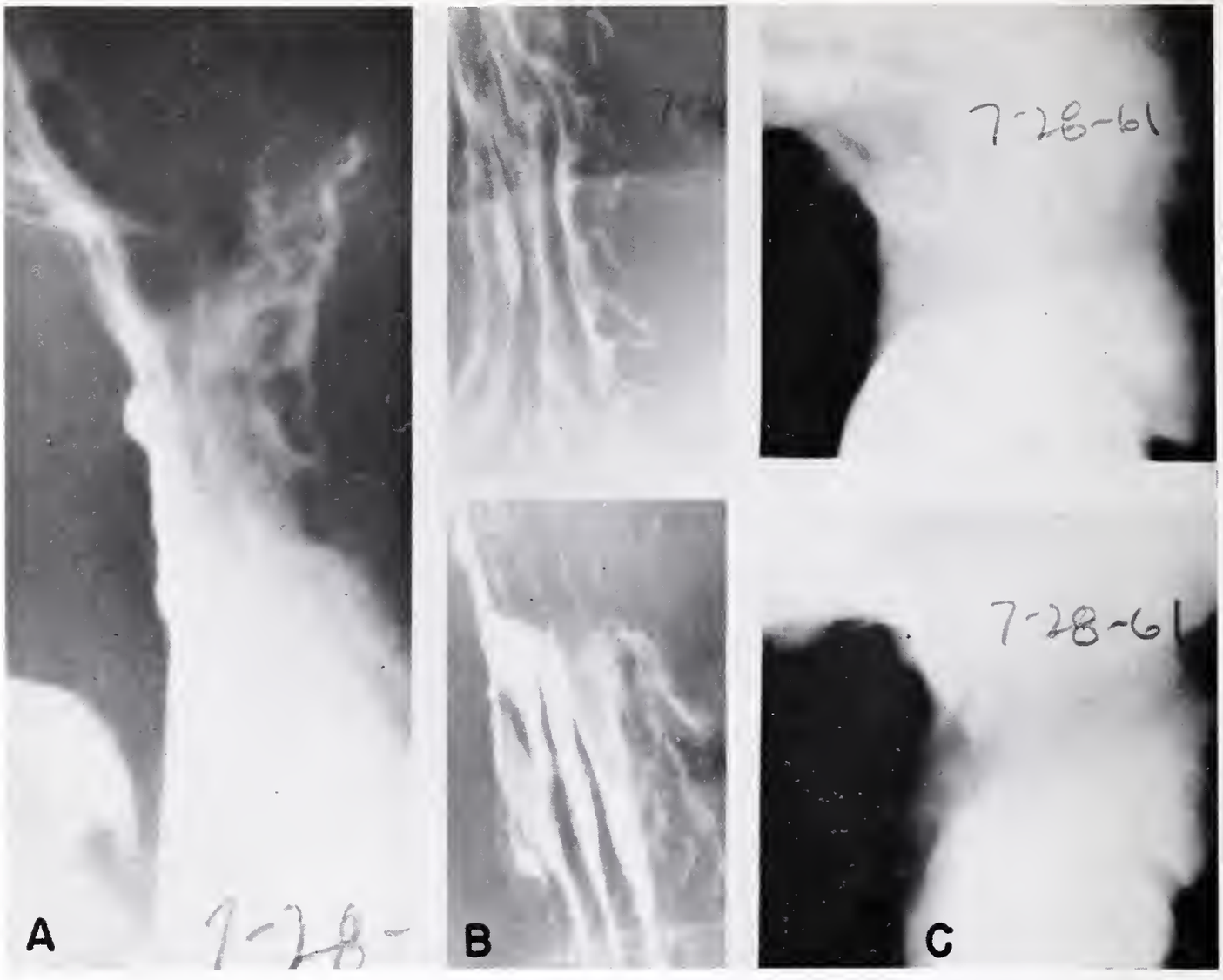


FIGURE 14.

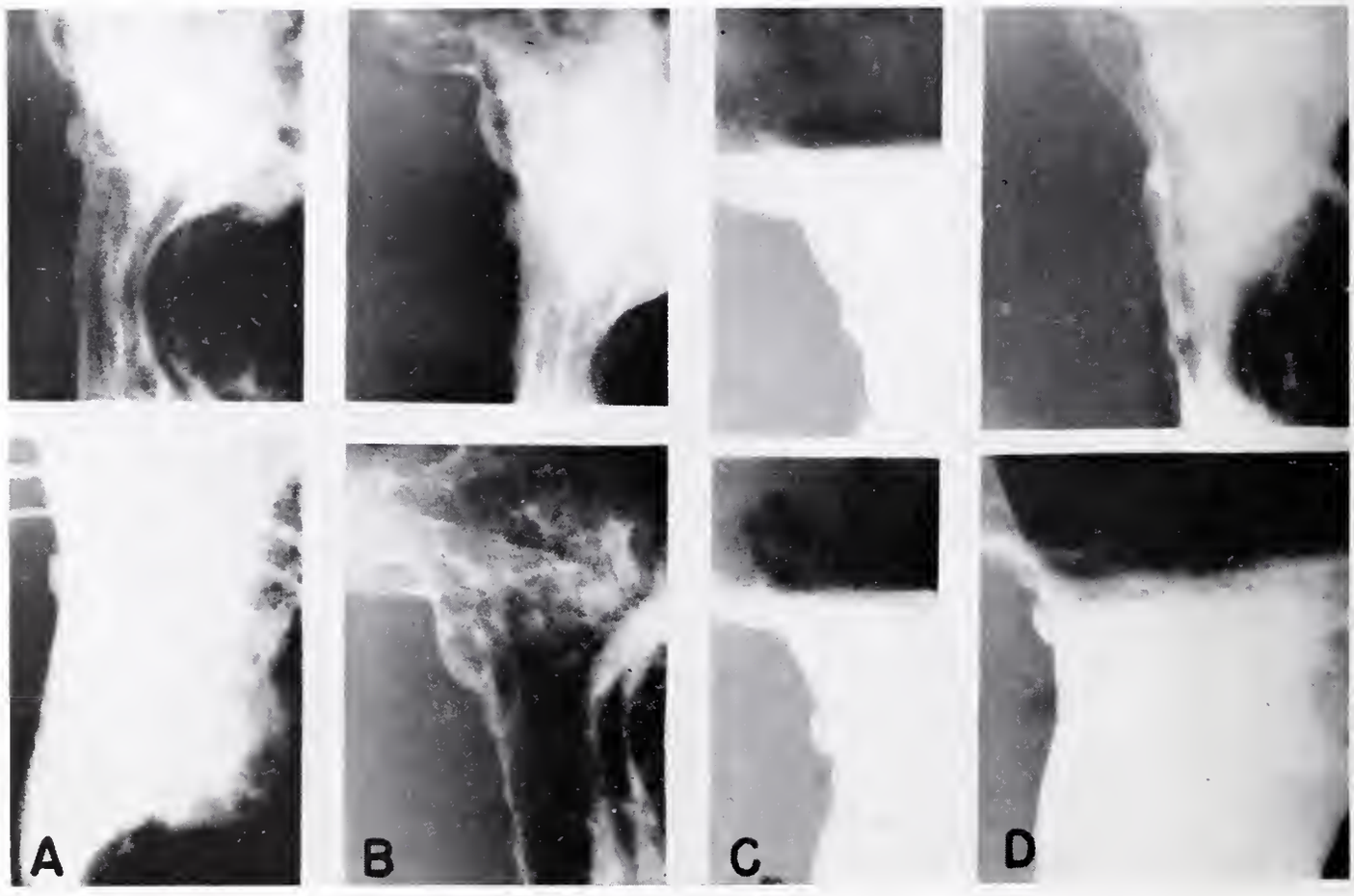


FIGURE 15.

TABLE 3.—*Location of Ulcers in 100 Cases.*

ROENTGENOGRAPHIC LOCATION	TOTAL NUMBER	NUMBER MALIGNANT
Body of stomach, lesser curvature	40	3
Body of stomach, posterior aspect of lesser curvature	34	5
Antral portion, anterior or posterior wall	5	
Antral portion, lesser curvature	5	1
Antral portion, greater curvature	1	
No definite crater recognized	17	1

TABLE 4.—*Relation of Size of Crater to Final Diagnosis.*

	AS MEASURED ON FILM		AS MEASURED ON SPECIMEN	
SIZE—MM	*Number benign*	*Number malignant*	*Number benign*	*Number malignant*
25–29	5	1	4	2
30–34	7	1	8	
35–39	3	1	4	
40–44	1	0		
45–49	1	0		1
50+	1	0	4	
Total	18	3	20	3
	21		23	

LOCATION NO CRITERION

Eight of the malignancies were located in the body of the stomach or near the lesser curvature, where three-fourths of all the ulcerating lesions occurred, as judged by the films (Table 3). It was not possible to ascertain the accuracy of roentgenographic localization because in many instances the descriptions of the gross specimen were not clear in this regard.

LARGE ULCERS SELDOM MALIGNANT

The number of ulcers with a diameter of 2.5 cm or larger was 21, as measured on the roentgenograms, 23 as measured on the resected specimens (Table 4). By either method, only three of these large ulcers were malignant.

RACE NOT A CONTRIBUTING FACTOR

A tabulation of the age-sex-race distribution of the 100 cases (Table 5) shows that only nine of the patients were less than 40 years of age, and that there was one neoplasm in this group. Although the Japanese comprised 60 per cent of the patients, only four of the ten malignancies occurred in this group. One neoplasm occurred among the 44 Japanese males, three among the 16 females. Among the 13 Caucasians, there were three cancers in the eight males, none in the five females. Thus, the particular susceptibility to gastric cancer

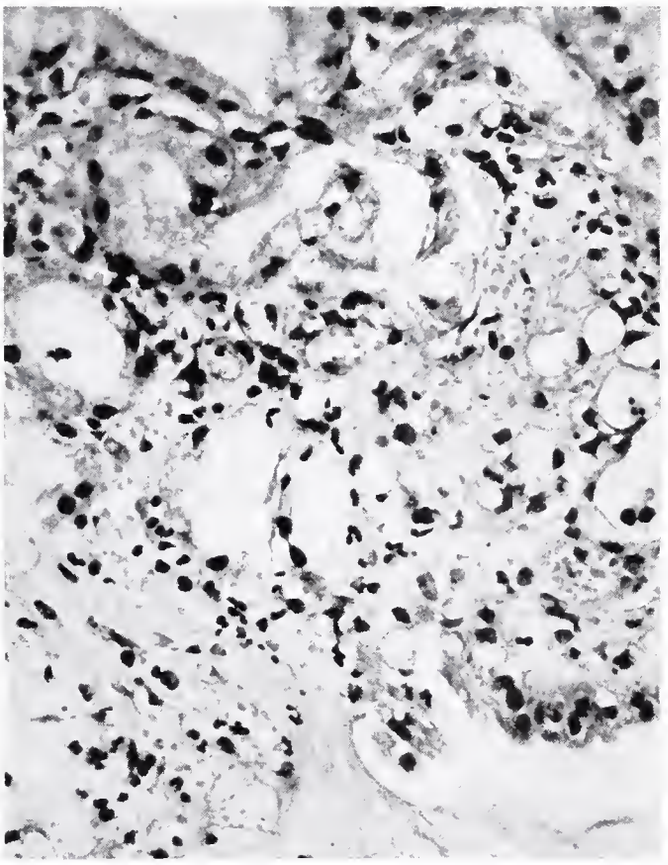


FIGURE 16.

TABLE 5.—*Age–Race–Sex Distribution of 100 Cases of Gastric Ulcer.*

	JAPANESE		CAUCASIAN		HAWAIIAN-CAUCASIAN		OTHER		TOTAL	
AGE	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
10–19					1	0			1	0
20–29	2	0			1	0			3	0
30–39	7	3			1	0	1 (1)	1	9 (1)	4
40–49	11 (1)	4 (1)	1	0	0	2	3	3 (1)	15 (1)	9 (2)
50–59	15	4 (1)	3	3	2	0	3	0	23	7 (1)
60–69	5	3	1 (1)	2	2	1	4 (1)	1	12 (2)	7
70–79	3	1 (1)	2 (2)	0			0	1	5 (2)	2 (1)
80+	1	1	1	0					2	1
Total	44 (1)	16 (3)	8 (3)	5	7	3	11 (2)	6 (1)	70 (6)	30 (4)
	60 (4)		13 (3)		10		17 (3)		100 (10)	

(Number of malignancies in parentheses).

TABLE 6.—*Interval from Roentgenological Examination to Surgery.*

TIME	NUMBER OF CASES	NUMBER OF MALIGNANCIES	TYPE OF ADENOCARCINOMA
0–4 days	21	0	
5–9 days	39	4	2 superficial, 2 arising at edge of chronic ulcer
10–14 days	23	3	1 superficial in situ, 1 arising at edge of chronic gastric ulcer, 1 invading into but through the muscularis
15–19 days	4	1	Mass lesion of stomach and esophagus
20–24 days	3	0	
25–29 days	1	0	
1–3 months	6	1	Invading muscularis
Longer	3	1	Metastases to nodes and liver

among Japanese, well documented elsewhere,[3] cannot be invoked as a contributing circumstance in the high diagnostic error of the present study.

The interval from roentgenological examination to operation (Table 6) was ten days or more for 40 per cent of the patients, including six of those who proved to have cancer. Thus the objective of "immediate" operation on all gastric ulcers was not completely attained.

X-RAY EXAMINATION OFTEN INADEQUATE

The roentgenological examination, judged only on the basis of the films, was rated as grossly inadequate in 54 per cent of the cases. The three basic criteria could be interpreted in only 34 per cent. This is not a reflection on the roentgenologists, because in a clinic where surgical therapy is the policy for all gastric ulcers, there is little incentive to the examiner to pursue the differential diagnosis; it is sufficient merely to verify that an ulcer is present. Among the seven cases which I erroneously pronounced benign, there was only one in which mucosal detail was shown. In three additional cases, the roentgenograms were nevertheless considered adequate to permit a confident diagnosis of benign ulcer. One of these was a superficial carcinoma, one a carcinoma in the edge of a chronic ulcer, and one a carcinoma invading the muscularis but still confined to the wall of the stomach.

TABLE 7.—*Number of X-ray Films per Case.*

NUMBER OF FILMS	CASES WITH THIS NUMBER OF VIEWS OF STOMACH	CASES WITH THIS NUMBER OF VIEWS OF ULCER AREA	CASES WITH THIS NUMBER OF SPOT FILMS
0–4	5	16	45
5–9	34	43	43
10–14	45	31	9
15–19	12	9	3
20–24	3	1	
25–29	1		

While the number of films is not necessarily an index of the adequacy of an upper gastrointestinal roentgen examination, an attempt has been made to indicate the completeness of the examination on this basis (Table 7). In 39 per cent of the cases, there were fewer than ten views of the stomach. In 50 per cent there were less than ten views of the ulcer area. In 88 per cent there were less than ten spot films of the area, and in half of these there were less than four.

In 17 cases we could not be sure whether or not a crater was actually present; these were recorded as "no definite crater." In two of these, no ulcer was seen in the resected specimen. One specimen was described as containing a healed ulcer, another an almost healed ulcer. In four of the gross specimens, the ulcer was described as "shallow." No specimen was available in one case because it was judged at the operating table to be an inoperable carcinoma. In the eight remaining cases, chronic ulcers were reported.

4/5 OF CARCINOMAS "SUPERFICIAL"

The type of malignancy encountered in this study was unusual in that eight of the ten carcinomas were of the "superficial" variety, which may explain some of my errors in roentgen diagnosis. Whether these errors could be eliminated by reexamination after a therapeutic test, is not known, because a period of medical therapy was not given. It would be of paramount importance to obtain this information, which could be done by deferring operation for three weeks after the initial roentgenological examination.

This much delay should not be objectionable for two reasons; first, most of the cases in which neoplasm was found did not come to operation for ten days or more anyway; and second, seven of the eight cancers coming to operation within three weeks were superficial and apparently slowly growing. The eighth case showed an obvious mass lesion and was long since beyond redemption. If roentgenographic disappearance of these ulcerations should occur under therapy, then my report[4] that this rarely, if ever, occurs with ulcerating neoplasms would be invalidated; as a corollary, the therapeutic test would then be discredited as an infallible procedure for the differentiation of benign from malignant ulceration.

CARCINOMA IN OLD ULCER?

Another interesting aspect of this material is the occurrence of three cases in which adenocarcinoma was reported in the margin of a chronic gastric ulcer. A planned investigation as outlined above might make it possible to determine whether this represents ulcerating carcinoma or malignancy originating in consequence of prolonged gastric irritation. If the latter were the case, one might expect to find carcinoma more frequently in connection with the larger, presumably more chronic ulcers. However, the present study shows no correlation between size and associated cancer.

IS GASTRIC CANCER DIFFERENT IN HAWAII?

I had a great deal more trouble interpreting the roentgenograms on these patients than I have experienced in investigations of gastric ulcer in Los Angeles. The Hawaiian cases presented a different manifestation of ulcer disease than I have been accustomed to, as witness the high incidence of "confined" carcinoma (8%) and of large craters (21%). Thus it may be that the criteria found applicable elsewhere are not reliable here. It may seem illogical that ulcers should look different roentgenologically in Honolulu than in Los Angeles, yet this is the only way I can account for the unexpectedly high error in the serious direction, i.e., calling cancer benign. The fact that the cancers were mostly in this category, and not in the categories diagnosed as equivocal or malignant, speaks for itself. The diagnostic error of 15 per cent was calculated on the basis of seven cancers being found among the 47 cases pronounced roentgenologically benign; but if we consider that of ten cancers in the entire series, seven were read as benign, we arrive at an error of 70 per cent for those who had cancer, a figure which is disturbing indeed.

It will be regrettable if the results of this project prompt our surgical colleagues to revive the thesis that a gastric ulcer can be diagnosed only under the microscope. Rather, these findings should stimulate interest in a planned study to ascertain whether a therapeutic trial will clarify those cases which are diagnosed erroneously in the initial roentgenograms.

SUMMARY

In a retrospective investigation of the accuracy of the roentgenographic diagnosis of gastric ulcer, an interpretation was attempted in the roentgenograms of 100 consecutive cases which were operated upon in Hawaii. In 47 of the patients, the roentgen appearance was thought to be consistent with a diagnosis of benign ulcer. It turned out that seven, or 15 per cent, of these were in fact cancer. The principal factors contributing to this degree of error were: (1) The case material was unusual in that eight of the ten cancers were relatively superficial, and 21 per cent of all ulcers in this series were 2.5 cm or more in diameter. (2) The number of roentgenographic views was in most cases insufficient to permit application of the roentgen diagnostic criteria. (3) An opportunity of evaluating the lesions after a therapeutic trial was not available, since these patients were not generally given a period of medical management before surgery.

The potential error of the initial roentgenographic interpretation of gastric ulcer underlines the desirability of a planned, controlled investigation to determine how effectively this error can be reduced by roentgen re-examination after a period of intensive medical therapy. ■

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In spite of certain deficiencies in Hawaii's quarantine regulations, mosquito-borne encephalitides had not occurred here as of 1961.

Arthropod-borne Virus Survey on the Island of Oahu, Hawaii

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• *Though virus-neutralizing material—which may have been antibody variously against Japanese B, St. Louis, and Western equine encephalitis viruses—was found in significant amounts in sera of five birds in Hawaii, no similar findings appeared in the blood of 749 other birds examined. Neither was evidence of virus found in 21,754 mosquitoes trapped, nor in encephalitis cases occurring in six humans and four horses. The authors believe that epidemics of arthropod-borne encephalitides could occur here, but haven't as yet.*

ARTHROPOD-BORNE viruses are known to be endemic in areas on the West Coast of mainland U.S.A.,[1] in Japan,[2] in New Guinea,[3] and in Queensland, Australia.[4] Hawaii has mosquito vectors capable of transmitting several of the known arthropod-borne viruses; migration and importation of birds, as well as the continuous growth of transpacific air traffic, increase the possibility of these viruses being introduced into Hawaii.[5]

Dengue virus type 1, responsible for an epidemic in Hawaii in 1943-44, is the only arthropod-borne virus known to have caused human illness in Hawaii.[6] However, virus-diagnostic facilities were not readily available to practicing physicians and public health workers in Hawaii until 1959, when a virus laboratory was established at the Hawaii State Health Department. Between 1954 and 1959, 15 clinically diagnosed human cases of viral or infectious encephalitis were reported to the State Health Department. To our knowledge none of these cases received adequate viral diagnostic studies. Therefore a survey was initiated late in 1959 to determine if arthropod-borne viruses were active in Hawaii.

MATERIALS AND METHODS

Human Studies. Human sera were obtained over an 18-month period from large clinics and hospitals, and from the Department of Health Laboratory on Oahu. These sera were from blood specimens collected for routine serologic procedures and clinical laboratory diagnostic tests. An attempt was made to obtain samples representative of all age groups. Sera were screened for Group B antibodies by the hemagglutination-inhibition test (HAI) of Clark and Casals[7] using dengue 1 and Japanese B encephalitis (JBE) virus antigens. Kaolin adsorption was used to remove nonspecific inhibitors. Sera were also absorbed with chick red blood cells. Sera inhibiting hemagglutination in dilutions of 1:10 or greater were screened for neutralizing antibodies against dengue 1, dengue 2, JBE, and St. Louis encephalitis (SLE) viruses.

Neutralization tests were done by intraeerebral inoculation of CFW strain mice according to the methods described by Kissling *et al.*[8] Undiluted

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Dr. Wallace and Dr. Kissling were on assignment to the Hawaii State Health Department from the Communicable Disease Center, U. S. Public Health Service, Atlanta, Ga.

† Supported in part by U. S. Public Health Service, National Institutes of Health, Grant E3446.

Received for publication October 15, 1963.

sera were screened against a calculated 32-LD50 dose of virus. Five three-week-old mice were used for each serum. Titration of each serum was not done, and neutralization indices were calculated on the results of the screening test by using a modification of the method of Reed and Muench.[9]

When possible, residence histories were obtained from all persons with a SLE or JBE neutralization index of 50 or greater, and from persons with dengue 1 or dengue 2 neutralization indices of 50 or greater, who were born after 1944.

During the survey, diagnostic studies were done on six patients with a clinical diagnosis of encephalitis, etiology unknown. Autopsy material for virus isolation was available from four of these patients, and paired sera were available from the other two. Brain tissue from one patient was contaminated. Brain tissue suspensions from the other three patients were inoculated intracerebrally into infant mice. Sera were tested for HAI and complement fixing (CF) antibodies using JBE and SLE antigens.[7, 10]

Avian Studies. From December, 1959, to June, 1960, blood specimens were obtained from wild birds caught on Oahu. Specimens were also collected from two groups of birds imported to Hawaii from India and Guam. Areas for trapping birds were selected on the basis of having relatively high coexisting populations of mosquitoes and birds. These areas were distributed over the coastal regions of Oahu and included piggeries, dairies, sugar cane plantations, and a large natural swamp.

Wild birds were caught in Japanese mist nets, bled from the jugular vein, banded with a small metal identification band on one leg, and released. Occasionally venipuncture was unsuccessful and blood was obtained directly from the heart. Imported birds being held at the Honolulu Animal Quarantine Station were bled by the same methods.

After collection, blood specimens were diluted with an egg yolk–antibiotic diluent and kept chilled until reaching the laboratory (usually within 12 hours) where they were stored at –60° C until processed. The avian blood specimens were tested individually for the presence of virus. Sera were tested for neutralizing antibodies against WEE (western equine encephalitis), EEE (eastern equine encephalitis), SLE and JBE viruses. Dilution of the blood in the field, virus isolation techniques, and neutralization tests in mice were performed by the methods described by Kissling *et al.*[8] with the exceptions that, for virus isolation, infant mice were used instead of three-week-old mice, and approximately 75 per cent of the samples were pooled for antibody determinations.

Serum pools consisted of equal portions of serum from two to six (usually five) birds of the same species caught in the same area. If antibody was detected in a pool, all specimens making up the pool were tested individually. Final dilutions of serum tested varied from 1:10 to 1:50, depending on the amount of blood collected and pooling procedures.

Neutralization tests for WEE and EEE antibody were performed in cultures of chick embryo fibroblasts, prepared by the method of Welch *et al.*[11] Equal portions of bird serum, and virus suspension calculated to have 25 $TCID_{50}$,* were mixed and incubated at room temperature for one hour. Following incubation, 0.2 ml of the mixture was inoculated into each of three tubes containing monolayers of chick embryo fibroblasts approximately 48 hours old. The inoculated tubes were then incubated at 37° C for one hour, after which the cells were washed with Hanks' balanced salt solution and new maintenance medium was added. Tubes were held at 37° C for two or three days and observed for cytopathic effects.

Viruses used in the neutralization tests were titrated at the same time the tests were run, and specific antisera were included in each test. WEE and EEE virus doses ranged from 10 to 50 $TCID_{50}$ and JBE and SLE virus doses ranged from 25 to 50 LD 50.

All serum specimens that neutralized virus in the original test were retested.

Mosquito Studies. Mosquitoes were collected from December, 1959, to October, 1961, and collections were limited to the night-biting mosquito, Culex quinquefasciatus Say. Most areas were sampled with light traps[12] and mosquitoes were collected in all the areas where birds were sampled, with the exception of the Quarantine Station. In addition to light trap collections at bird-sampling areas, resting-site collections were made at poultry farms located in three other areas. Therefore mosquitoes were obtained from several areas distributed over the island of Oahu and considered to be ecologically suitable for arthropod-borne viruses.

Dead mosquitoes found in the light traps were discarded. Live mosquitoes were placed in ice cream cartons with cheesecloth covers and transported to the laboratory in a chest containing ice. At the laboratory mosquitoes were anesthetized with chloroform, identified, pooled, and stored in air tight tubes at –60° C until tested. Mosquitoes collected at Kawainui Swamp were inadvertently stored at –20° C. Pools consisted of approximately 70 female Culex quinquefasciatus Say mosquitoes collected from the same area. Engorged and unengorged mosquitoes collected by light traps were pooled separately.

Most of the mosquitoes collected at resting sites were engorged, so no attempt was made to sepa-

* Tissue Culture Infectious Dose for 50 per cent of cultures inoculated = $TCID_{50}$.

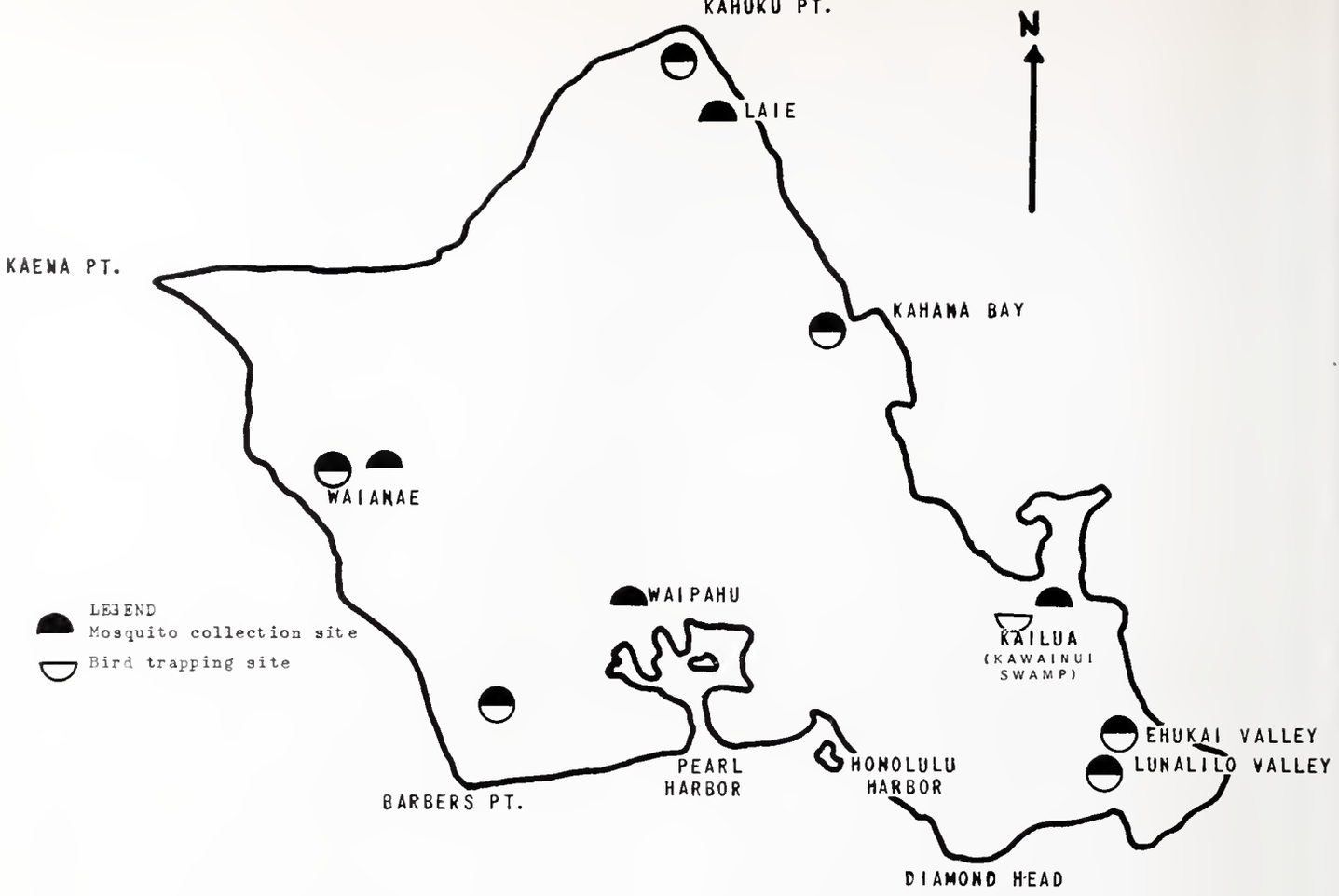


FIG. 1. *Mosquito collection and bird trapping sites on the island of Oahu, 1959-1961.*

rate unengorged from engorged mosquitoes collected in this manner.

Mosquitoes were tested for virus by intracerebral inoculation of infant mice, using the method of Kissling *et al.*,[8] with the exception that the diluent was made with calf serum instead of horse serum. Calf serum used in the diluent was known to be free of SLE, JBE, WEE, and EEE virus antibodies.

Domestic Animal Studies. Sera from four horses kept near a horse that had died with encephalitis were tested for CF antibodies against WEE, EEE, and SLE virus.[10]

Strains of Virus Used. Strains of viruses used in the serologic tests and their passage history were as follows: dengue 1 (Hawaiian) M-124; dengue 2 (Tr 1751) M-56; EEE (Arth. 167) M-2, E-1; WEE (?) E-3; SLE (904) M-4; JBE (Nakayama) passage history unknown.

TABLE 1.—*Prevalence of Dengue 1 and JBE Virus HAI in Sera of 912 People by Age Groups. Oahu, Hawaii, 1960-61.*

AGE YEARS	NO. OF SERA TESTED	NO. OF SERA INHIBITING HEMAGGLUTINATION*
0–9	133	21
10–19	122	13
20–29	155	27
30–39	165	36
40–49	164	52
50–59	104	52
60+	69	37
Totals	912	238

* Sera in dilutions of 1:10 or greater that inhibited hemagglutination by dengue 1 virus or JBE virus or both. (The HAI tests were used for screening and were not considered to be specific therefore, results of hemagglutination inhibition of each of the two viruses were not listed separately.)

RESULTS

Human Studies. Of sera from 912 people examined for HAI antibody to JBE and dengue 1 viruses, 238 were found to inhibit hemagglutination at dilutions of 1:10 or greater. Each of these 238 specimens was then tested for neutralizing antibody to JBE, SLE, dengue 1, and dengue 2 viruses, and 91 had neutralization indices of 50 or greater to one or more of these viruses. Serologic results by age are given in Tables 1 and 2.

Avian Studies. Of sera from 754 birds, only

TABLE 2.—*Prevalence of Virus Neutralizing Antibody in Sera of 238 People by Age Group and Virus Neutralized. Oahu, Hawaii, 1960-61.*

AGE YEARS	NO. TESTED	NEUTRALIZING ANTIBODY*				TOTAL SAMPLES WITH NEUTRALIZING ANTIBODY†
		JBE	*SLE*	*D 1*	*D 2*	
0–9	21			1	1	1
10–19	13			3		3
20–29	27	3	2	3	3	8
30–39	36	5		7	6	11
40–49	52	1	1	15	10	19
50–59	52	6	3	12	15	27
60+	37	2	1	9	14	23
Totals	238	17	7	50	49	92

* Index of 50 or greater.
† Some specimens had indices of 50 or greater to more than one antigen.

TABLE 3.—*Avian Blood Specimens Collected, by Species and Area. Oahu, Hawaii, 1959-60.*

AREA	BAR. DOVE (1)	SP. DOVE (2)	N. AM. CARD. (3)	BR. CARD. (4)	SPARROW (5)	RICEBIRD (6)	WHITE-EYE (7)	MYN. (8)	MISC. (9)	TOTAL
Kawainui Swamp	19	37	29	2		4	21	9	36	157
Ehukai Valley	44	3	7	25	12	1	1		4	97
Lunalilo Valley	44	1	11	1	6	5	2		1	71
Waianae	116	13	1	2	4	1		1		138
Kahuku	7		7	2		3	3		1	23
Kahana Valley	35	12	6				7	8	26	94
Barber's Point	92	9	2		39					142
State Quarantine Station									32	32
Total	357	75	63	32	61	14	34	18	100	754

(1) Barred Dove, *Geopelia striata*
(2) Spotted Dove, *Streptopilia chinensis chinensis*
(3) North American Cardinal, *Richmondena cardinalis*
(4) Brazilian Cardinal, *Paroaria cucullata*
(5) House Sparrow, *Passer domesticus*
(6) Ricebird, *Munia nisoria*
(7) White-eye, *Zosterops palpebrosus japonicus*
(8) Mynah, *Acridotheres tristis*
(9) 4 species of resident birds, 1 migratory species (*Pluvialis dominica*) and 32 imported birds of 2 species (17 swiftlets and 15 francolin partridges).

four were found to have neutralization indices of 50 or greater to one or more of the viruses tested. These results were reproducible in subsequent tests. Table 3 gives the number of birds bled by species and area caught. Geographic location of sampling areas can be seen in Fig. 1. Table 4 lists the species of birds that had neutralization indices of 50 or greater and the areas and dates of capture.

The positive white-eye and North American cardinal were in a group of 63 birds that were captured at Kawainui Swamp between December 3 and December 9, 1959. There were a total of seven white-eyes and 12 North American cardinals in this group. Between May 17 and May 20, 1960, birds were again caught and bled at Kawainui Swamp. At this time a total of 91 specimens were collected and tested, and no specimens were found to have antibody. These included 17 North American cardinals and 15 white-eyes. Leg bands were not used during the first sampling at Kawainui Swamp so it was not known if birds bled during the first sampling were recaptured.

The positive barred dove was one of 44, in a total of 97 birds captured at Ehukai Valley December 16 and 17, 1959.

No viruses were isolated from the blood of 749 birds tested.

TABLE 4.—*Neutralization Indices of Sera from Four Wild Birds by Species, Area and Data Collected. Oahu, Hawaii, 1959-60.*

SPECIES—DATE COLLECTED	AREA	NEUTRALIZATION INDEX JBE	SLE	WEE	EEE
White-eye 12/3/59	Kawainui Swamp	100	60	0	0
N. Am. Cardinal 12/4/59	Kawainui Swamp	0	0	50	0
Barred Dove 1/14/60	Ehukai Valley	63	0	0	0
Francolin 2/16/60	New Delhi, India*	100	0	0	0

* Imported for release in Hawaii.

Mosquito Studies. No viruses were demonstrated in the 303 pools of 21,754 mosquitoes examined. The number of mosquitoes tested by area of capture can be seen in Table 5. Figure 1 shows all areas where mosquitoes were obtained.

Other. Studies on specimens from encephalitis cases, both humans and horses, yielded negative results.

DISCUSSION

With a few exceptions, residence histories were obtained on people with neutralizing antibodies. The individual in the 0-9-year-old age group with antibodies that neutralized dengue 1 and 2 viruses was an infant under six months of age; his mother, who had resided in the Philippines, also had antibodies to the same viruses.

The three persons in the 10-19-year-old age group with dengue 1 antibody had spent all their lives in Hawaii and were old enough to have been exposed during the epidemic of dengue in Hawaii during 1943-1944.

TABLE 5.—*Number of Female Culex quinquefasciatus Mosquitoes Trapped by Area and Pools Tested for Virus. Oahu, Hawaii, 1960-61.*

AREA	TOTAL NUMBER OF MOSQUITOES	NUMBER OF POOLS TESTED*
Kawainui Swamp	7,177	100
Ehukai Valley	111	3
Kahuku		
Bird collecting area	12	2
Laie poultry in Laie town	2,999†	40
Lunalilo Valley	65	2
Waianae		
Bird collecting area	374	3
Mikilua Valley poultry	4,056†	55
Barber's Point		
Bird collecting area	651‡	13
Izumi poultry in Waipahu	6,131†	83
Kahana Valley	178	2
Total	21,754	303

* Average size of pool 72.
† Resting site collections.
‡ 191 were caught with a light trap; the remainder were resting site collections.

Persons in the other age groups with neutralizing antibody had resided in areas where these viruses were known to have occurred, such as the Philippines, Japan, and U. S. mainland.

The finding of virus-neutralizing substances in three nonmigratory birds is difficult to explain. It is possible that the neutralizing substances in the blood of these birds was not antibody; however, serum of two of the three birds specifically neutralized only one of four viruses. Serum from the other neutralized both JBE and SLE viruses, but these viruses are closely related antigenically and some cross-neutralization could be expected. If in fact the neutralizing substance found in these birds was antibody, then there is evidence that arthropod-borne viruses have recently been active in Hawaii. It is possible that virus was introduced under circumstances that limited its spread. All three birds were mature at the time of capture and could have been infected any time within two or three years of their capture.

Another explanation for the serologic findings in the two birds at Kawainui Swamp and the dove at Ehukai Valley is that unidentified viruses antigenically related to JBE and WEE viruses had been present in one or both of these areas. It is also possible for barred doves to range between Kawainui Swamp and Ehukai Valley.

Finding JBE antibody in a game bird imported from India indicates the potential hazard of importing birds from areas where arthropod-borne viruses are known to be endemic. Some arthropod-borne viruses may circulate in the blood stream of birds for at least 72 hours at levels high enough to infect mosquitoes.[13] This is well within the time it takes to transport birds by air from the Far East to Hawaii and from most areas of the mainland. Authorities in Hawaii now require that birds imported from foreign countries be held for two weeks in mosquito-proof quarters prior to release. However, there are no such restrictions on birds imported from the mainland United States.

Although it is of interest to speculate on the serologic findings in the resident birds, the survey in general did not reveal evidence of recent arthropod-borne virus activity on Oahu. Diagnostic studies of several human cases of encephalitis did not demonstrate that an arthropod-borne virus was the causative agent. Investigations of encephalitis in horses also yielded negative results. No viruses were isolated from the blood of 749 resident birds or from 21,754 mosquitoes, although, compared to the total mosquito and bird populations of Oahu, the samples were small. Also the 7,177 mosquitoes collected at Kawainui Swamp were inadvertently stored at –20° C for several weeks before being tested, making the negative results from this group of doubtful significance.

Apparently the island of Oahu does not have situations ecologically conducive to long-term maintenance of the arthropod-borne encephalitis viruses. For instance, we found no rookeries containing large populations of immature birds in areas supporting—even intermittently—dense mosquito populations. Mosquito populations on the island of Oahu build up sporadically, and are focal in distribution.

Nevertheless it is our opinion that if certain arthropod-borne viruses (e.g., St. Louis encephalitis, Japanese B encephalitis, and possibly western equine encephalitis) were introduced into areas of Oahu with relatively large populations of birds at a time of maximum mosquito breeding, an epidemic might occur. Kawainui Swamp during the months of December, January, and February is an example of such an area. The degree of human involvement likely in a localized epidemic is purely a matter of conjecture. Certainly efforts should be continued to prevent the introduction of mosquitoes into Hawaii from other areas, as well as to regulate the importation of birds.

SUMMARY

From December, 1959, through September, 1961, a survey was conducted to determine if arthropod-borne viruses were active on the island of Oahu.

Tests for HAI antibody to dengue 1 and JBE viruses were conducted on sera from 912 human residents of Oahu representing various age groups. Of these sera 238 inhibited hemagglutination in dilutions of 1:10 or greater, and were further tested for neutralizing antibody against dengue 1 and 2, JBE and SLE viruses.

In addition to the serologic survey, diagnostic studies were performed on specimens from six patients with clinical diagnosis of encephalitis. Brain tissue suitable for virus isolation attempts was available from three of the six patients.

Blood specimens from approximately 750 wild birds captured in various areas of Oahu were tested for viruses and for neutralizing antibodies against Japanese B encephalitis, St. Louis encephalitis, western equine encephalitis, and eastern equine encephalitis viruses. Blood from 32 birds imported from India and Guam were also tested for viruses and JBE neutralizing antibody, and 21,754 female Culex quinquefasciatus Say mosquitoes trapped at or near the areas where birds were captured were tested for the presence of virus.

Generally, the survey yielded little evidence that arthropod-borne viruses have been active in Hawaii since the dengue 1 virus epidemic of 1943-1944.

Acknowledgments and references will appear in the author's reprints. ■

A simple reconstructive procedure can give a good cosmetic result in cancer of the lip.

The Cross-lip Flap in the Management of Carcinoma of the Lip

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• *In surgical treatment of large cancers of the lip, a reconstructive procedure devised over a century ago, and perfected in both Europe and the United States over the intervening years, is still the method of choice. Herein are reported three cases from the Cleveland Clinic.*

CANCERS which occupy no more than one-fourth of the lip can be adequately treated by wedge resection and primary closure. Larger lesions require a reconstructive procedure to prevent a tight, puckered lip. The simplest and most useful technic for this reconstruction is the cross-lip flap, most commonly known as the Abbé[1] flap procedure.

In 1898 Abbé described the transferring of a vermilion-bordered flap from the lower lip to the upper lip in the treatment of a cleft lip deformity. In 1848 Stein[2] described the transferring of a flap from the upper lip to the lower lip in the treatment of carcinoma of the lower lip. In 1874 Eslander[3] described the rotation of a flap around the angle of the mouth from the upper lip to the lower lip. Since these pioneering efforts, many surgeons—among them Brown,[4] Martin,[5] Webster,[6] Kazanjian,[7] and Cannon[8]—have modified and refined these techniques. Since these three flaps are similar, it is easier to refer to them jointly by the descriptive term "cross-lip flap," rather than by their respective eponyms. The purpose of this paper is to present the details of the technique of the cross-lip flap, and to demonstrate its usefulness by presenting three case reports.

TECHNIQUE

The procedure consists of a 180° rotation of a full-thickness, triangular flap of tissue from one lip into a defect in the opposite lip (Fig. 1). The flap is nourished by the labial artery and vein, which are left intact in the narrow base.

Before infiltration with a local anesthetic, it is important to outline with a dye the area to be excised, together with the flap for repair. The local anesthetic distorts and discolors the tissue, making planning difficult. The mucocutaneous junction on both sides of the lesion and on all sides of the flap should be marked by puncturing the skin with a fine needle, its tip dipped in methylene blue. These points must be carefully approximated for a satisfactory result.

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Received for publication May 5, 1963.

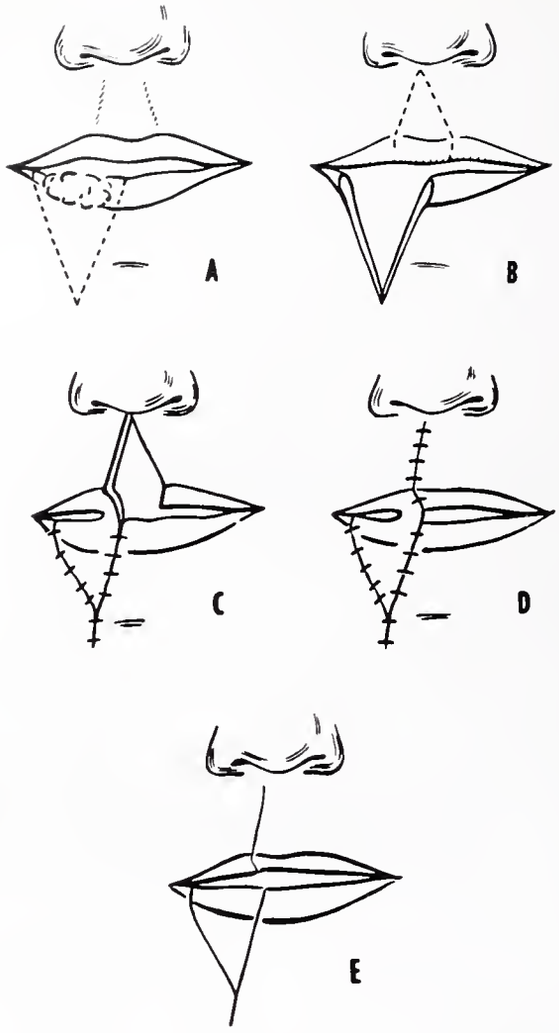


FIG. 1. *A. Excision and primary closure on this lesion would produce a tight, puckered lip. B. Outline of the composite flap used for closure of the lower lip defect. C. The flap is nourished by the labial vessels left intact in the narrow base. D. The flap is rotated 180° into position in the lower lip; the donor site in the upper lip is closed primarily. E. The pedicle is divided on the tenth to the eighteenth postoperative day.*

The width of the flap should be no more than half the width of the tissue excised—this makes both lips symmetrical, as the donor lip is decreased in size by the exact amount by which the recipient lip is increased in size. The flap should be hinged to one side of the defect in such a fashion that it will lie in the center of the defect when it is rotated 180° into position.

The flap is incised, leaving the labial artery and vein attached on one side. The posterior position of the labial artery and vein permits incision through the anterior half of the vermilion border (Fig. 2). This facilitates the 180° rotation and permits accurate approximation of all vermilion borders at the time of the initial rotation. The mucosa and muscle layers are closed with fine catgut. The skin is closed with fine silk or nylon sutures. A Barton head dressing is applied until the patient becomes adjusted to keeping his mouth closed. If

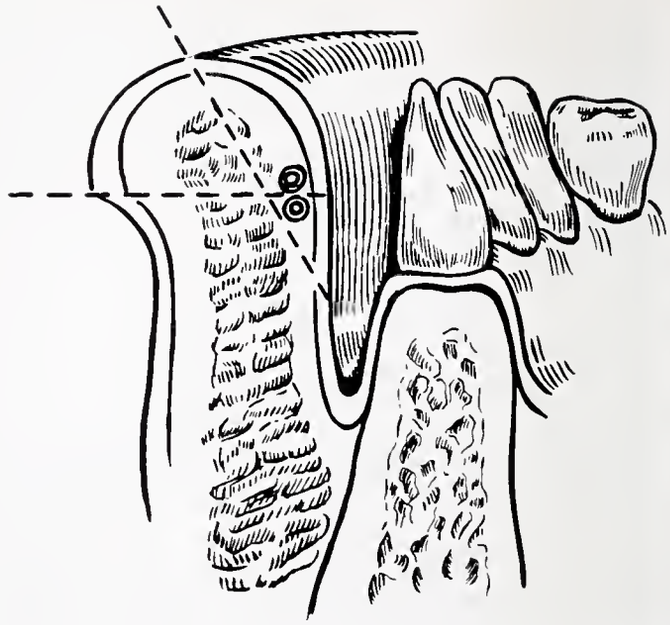


FIG. 2. *The posterior position of the labial vessels permits incision through the anterior half of the vermilion border. This narrow pedicle facilitates the rotation.*

general anesthesia has been used, a nasogastric tube is placed on suction until there is no nausea, and peristalsis is present. The patient usually begins to take full liquids on the first postoperative day. Tracheostomy has not been necessary. Nose drops are useful to maintain an open nasal airway.

The pedicle is divided ten to eighteen days later. Any necessary revision of the vermilion is also performed at that time.

REPORT OF REPRESENTATIVE CASES

CASE 1. A 61-year-old policeman was admitted to the Cleveland Clinic Hospital on June 25, 1962, for treatment of a basal-cell carcinoma involving the central portion of the upper lip, columella, and distal nasal septum (Fig. 3 A). Treatment at another hospital consisted of five operations, six courses of irradiation, application of various acids, and many electrocoagulations over the previous fifteen years. On June 26, 1962, a wide local resection was performed under local anesthesia (Fig. 3 B). The middle half of the upper lip, all of the columella, the distal septum, a portion of the nasal tip, and the superficial portion of the maxilla were removed. A cross-lip flap was rotated into the defect from the lower lip. Figure 3 C shows the patient on the third postoperative day with the pedicle still attached. On the seventeenth postoperative day the pedicle was divided under local anesthesia.

Figures 3 D & E show the result six months after surgery. The columella has since been reconstructed by a left nasolabial flap.

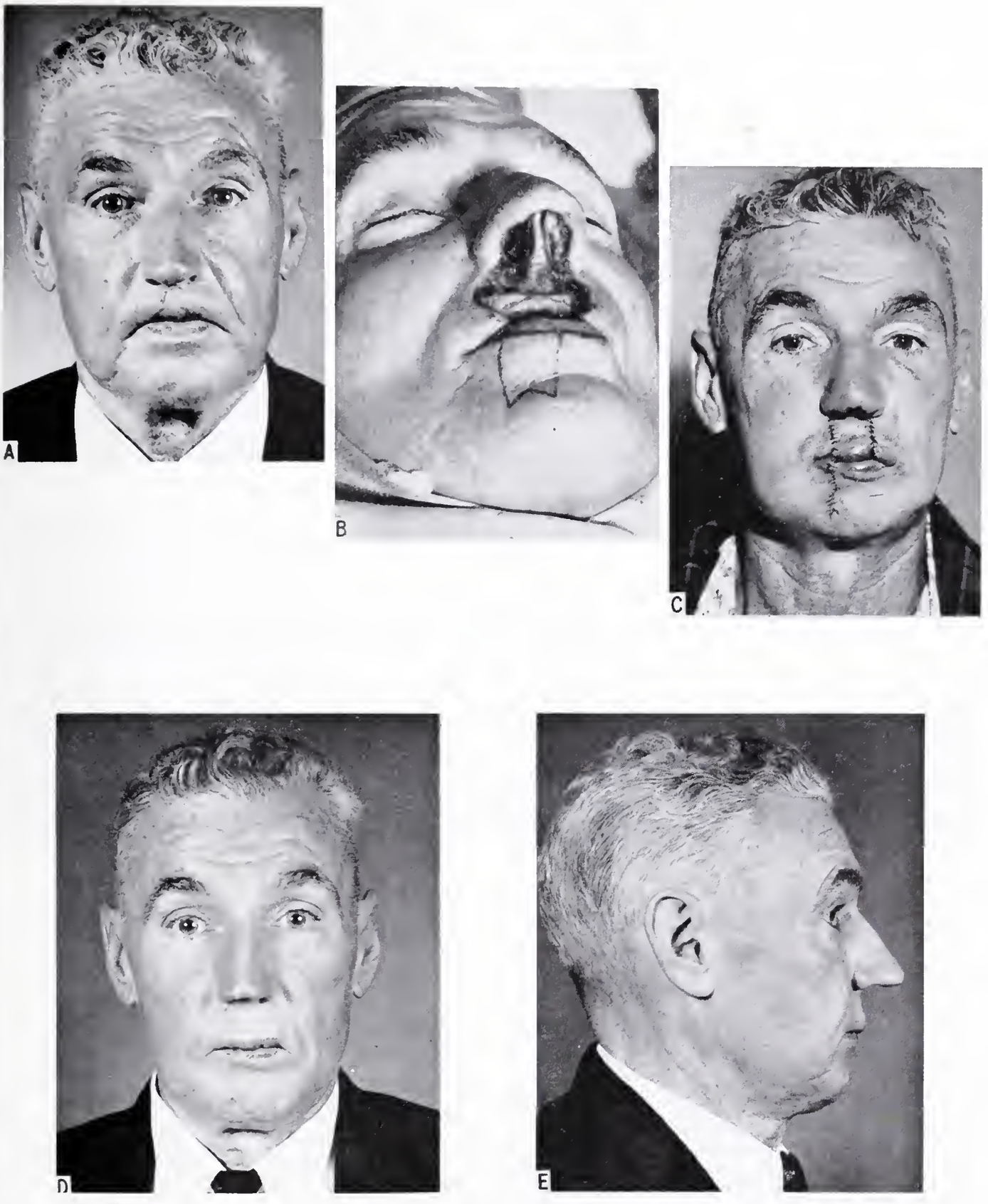


FIG. 3. *A. Patient with basal-cell carcinoma of upper lip, columella, and distal septum. B. Surgical defect plus outline of the flap to be used for closure. C. Third postoperative day; pedicle still attached. D, E. Six months after surgery; the columella has since been reconstructed by a left nasolabial flap.*

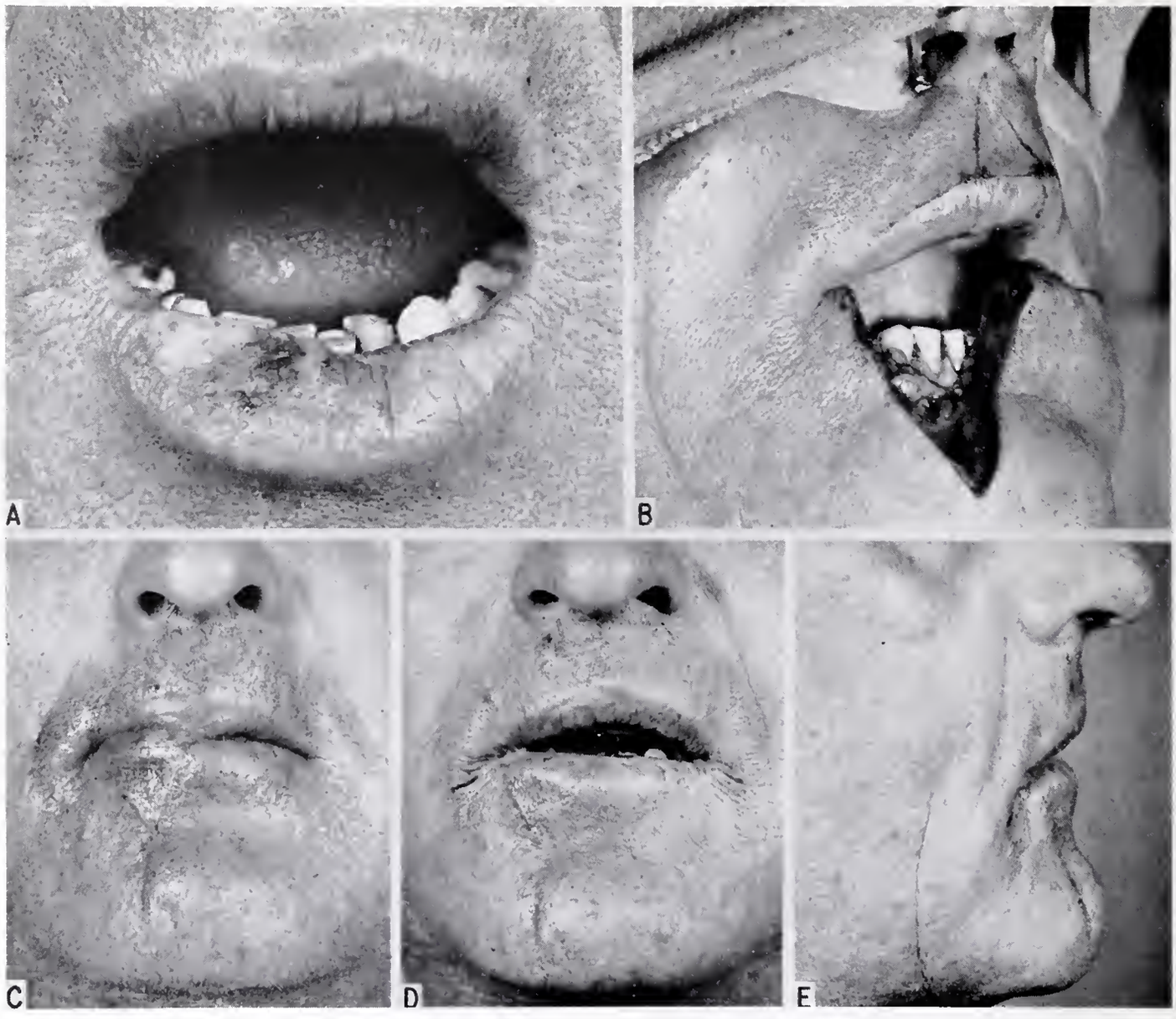


FIG. 4. *A. Patient with squamous-cell carcinoma of the right lower lip. B. Surgical defect plus outline of the flap to be used for closure. C. Twelfth postoperative day; pedicle still attached. D, E. Two months after surgery; lateral view shows the full, normal, everted lip that results from this type of repair.*

CASE 2. A 51-year-old laborer was admitted to the Cleveland Clinic Hospital on September 25, 1962, for treatment of squamous-cell carcinoma involving the vermilion surface of the right lower lip (Fig. 4 A). The lesion had slowly increased in size for the previous seven months. On September 26, 1962, a wide local resection was performed (Fig. 4 B). The defect was closed by rotating a cross-lip flap from the upper lip into the defect on the lower lip. Figure 4 C shows the patient on the twelfth postoperative day with the pedicle still attached. The pedicle was divided on the nineteenth postoperative day under local anesthesia.

Figures 4 D & E show the result two months after surgery. The lateral view shows the full normal everted lip that results from this type of repair. A primary closure of a lesion this large would have resulted in a tight, puckered lower lip.

CASE 3. A 73-year-old clergyman was admitted to the Cleveland Clinic Hospital on September 21, 1960, for treatment of a squamous-cell carcinoma involving more than half of the lower lip plus the left commissure (Fig. 5 A). The lesion, not previously treated, had been present for many years. On September 22, 1960, a wide local resection was performed. Figure 5 B shows the outline of the resection and also the outline of the upper lip flap that was rotated into the lower lip defect for closure. This flap was rotated around the left angle of the mouth to give the result shown in Figure 5 C. The microstomia was corrected by means of a Y-to-V procedure to give the final result shown in Figures 5 D & E, nine months after surgery.

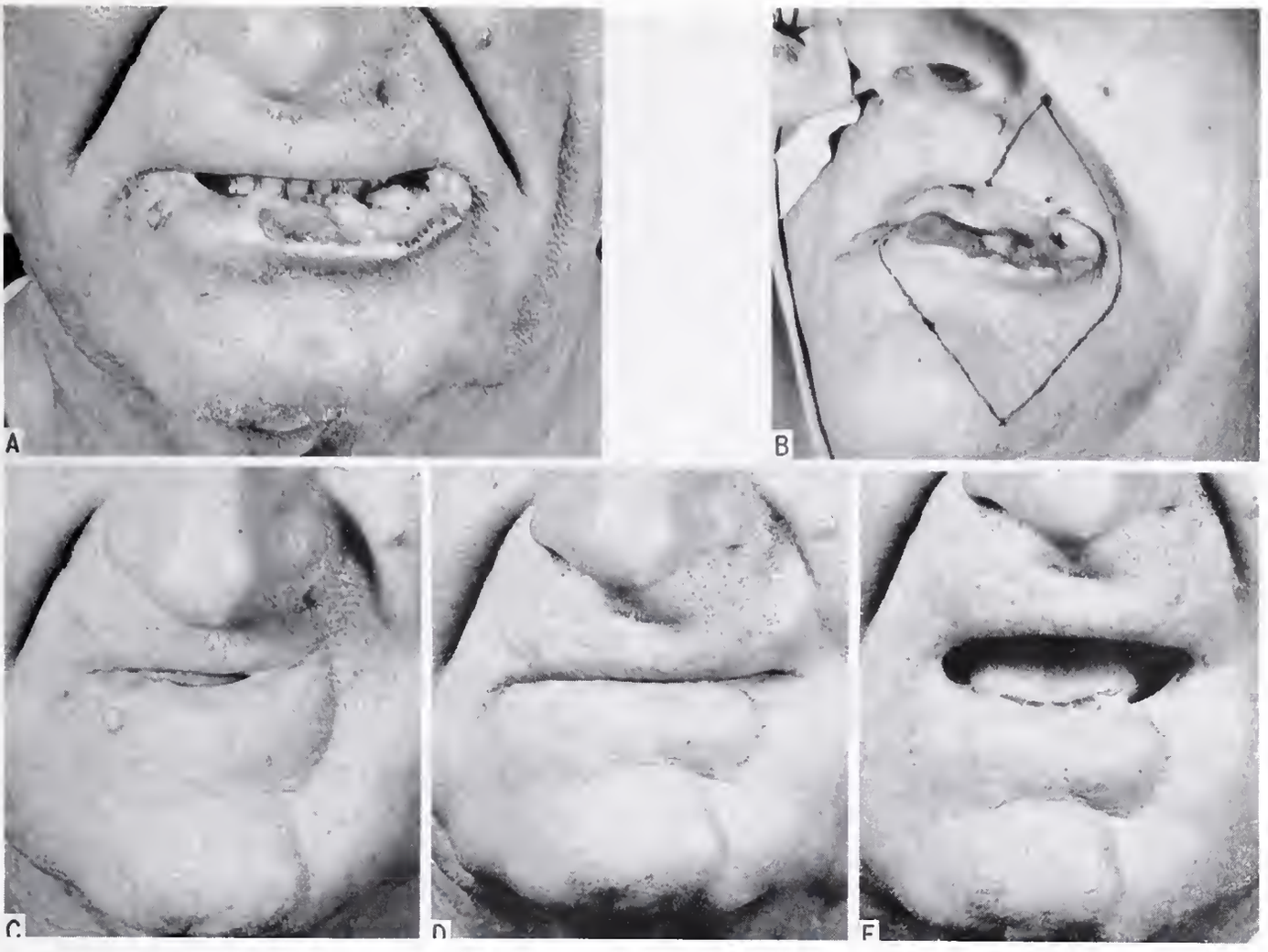


FIG. 5. *A. Patient with squamous-cell carcinoma involving more than half of the lower lip plus the left commissure. B. Outline of the area (two-thirds of the lower lip) to be resected plus the flap to be used for closure. C. Microstomia resulting from sacrifice of two-thirds of the lip. D, E. Following correction of the microstomia by means of a Y-to-V procedure; nine months after surgery.*

DISCUSSION

The cross-lip flap technique is a useful tool in the management of those cases of carcinoma of the lip which are too large for wedge resection and primary closure. It is rare today for a patient to neglect a lip lesion until it is so large that a procedure more complex than the cross-lip flap is necessary for reconstruction. As illustrated in Case 3, lesions involving slightly more than half of the lip can be adequately reconstructed by this method.

The functional and cosmetic results of this type of repair are excellent. The color and texture of the transplanted lip tissue match well with the adjacent lip tissue. It has been demonstrated that sensory and motor functions are restored within a two-year period.[9] The anatomic integrity of the orbicularis oris muscle is maintained, enabling the patient to perform all physiologic functions in a normal manner. This eliminates such problems as oral incontinence and drooling, which sometimes occur when less functional tissues are used in labial reconstruction.

SUMMARY

The technique of the Abbé or cross-lip flap procedure has been described and illustrated. Its usefulness in the management of carcinoma of the lip has been demonstrated by the presentation of three representative case reports. ■

888 So. King St.

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Think of segmental infarction of the omentum if you encounter continuous abdominal pain with normal white count and temperature.

Idiopathic Omental Infarction

THOMAS H. RICHERT, M.D., *Honolulu*

• *This case report calls to the surgeon's attention the entity of infarction of the omentum, to be considered in the differential diagnosis of the "surgical abdomen."*

IDIOPATHIC omental infarction, or omental necrosis, is a rather rare condition. The first case was reported in 1896 by Bush.[1] In a review of the literature in 1955, 33 cases were uncovered. The author added five.[2] Blandsfield and Jameson added two more cases in 1959.[5] To our knowledge to date, no one has made the correct preoperative diagnosis. In order of frequency, the mistaken diagnoses have been acute appendicitis, acute cholecystitis, perforated peptic ulcer, acute pancreatitis, mesenteric thrombosis, and tumor of the colon.[4]

Idiopathic omental infarction has never been satisfactorily explained. A theory considered by Rabinovich and Pines[3] was that stretching of the omental veins caused separation of the endothelial cells, with resultant thrombosis.

YOUNG MEN AFFLICTED MOST

Greatest frequency of this condition is in the fourth decade, although cases have been reported from age 3 to 68. Males predominate about five to one. Clinical picture and symptomatology are not constant. The only constant factor is pain, which tends to localize and be quite severe, the localization depending on the area of omentum involved. Nausea and vomiting are absent. A stooped posture is often assumed in order to lessen abdominal tension. A mass is often palpable if guarding is not too great.

A review of The Queen's Hospital medical records for the past 17 years revealed no cases.

CASE REPORT

A 33-year-old white man, who had had no previous surgery, was first seen October 23, 1963, complaining of pain and soreness of 12 hours' duration in the right periumbilical area and right lower abdominal quadrant. The pain was constant and moderately severe. There were no chills, nausea, or vomiting. No recent injury or illness had occurred. He had eaten a normal breakfast. There were no urinary system complaints, and stools were normal and firm.

Examination disclosed a well-developed, well-nourished man of 33, slightly overweight, but with good muscular tone; walking in a stooped posture; alert, and joking about his "painful belly." General physical examination was negative except for abdomen. Active bowel sounds were present. Left belly was negative except for referred pain into the right paraumbilical and right flank area.

Received for publication January 4, 1964.

Marked, acute pain on attempted deep palpation in the right middle and upper belly and along the lateral wall was noted. On rectal examination there was acute tenderness high on the right side. Rebound pain in McBurney's area was acute. Temperature, 98.6°; urine, normal; WBC, 6,750—segs. 52, lymphs. 44, eosins. 1, and monos, 3.

The patient was not ill enough, or the picture clear enough, to warrant immediate surgery, so he was sent home to report back any changes in his condition. He went back to work that afternoon and the next day; but on the third day he called in and stated that during the night the pain had become very severe. Though he did not feel bad, he could not take the pain.

When seen at the office on this third day of illness, he had a normal temperature; WBC was 7,600—segs. 61, lymphs 32, monos. 4, eosins. 3. Pain, tenderness, and guarding were now in the right lateral and upper belly, and there was a questionable palpable liver edge or mass in this area. Plain film of the abdomen revealed no abnormality. Because of the severity of the pain, the patient was admitted to The Queen's Hospital for exploratory laparotomy, with a tentative diagnosis of acute cholecystitis.

Right paramedian incision disclosed a moderate amount of serosanguinous fluid. Liver and gall bladder appeared normal. An infarcted and pregangrenous mass of greater omentum, measuring 8 cm by 14 cm, adherent to the right lateral belly wall, 5 cm to 7 cm below the right lobe of the liver, was found. The mass was easily freed from the parietal peritoneum and brought through the wound. The omental mass was a long tongue-like process of the right margin of the greater omentum. The infarcted area was resected, and prophylactic appendectomy was done. Postoperative course was uneventful. The patient was discharged on the fifth postoperative day, and sutures removed on the seventh day. He has remained well to date.

CONCLUSION

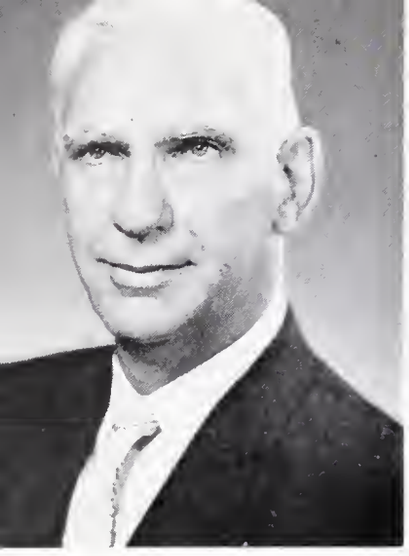
The constant presence of pain, normal white count, and absence of fever should cause the surgeon to entertain segmental infarction of the omentum in his differential diagnosis of the "surgical belly."

839 So. Beretania St.

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Please—when you give to your medical school, send it through the AMA-ERF so Hawaii gets credit for making the donation. It is transmitted intact, in your name.





The President's Page

Now that my term of office is over, the question I am most frequently asked is "Are you glad it is all over?" As yet I cannot truthfully say "yes" or "no."

Yes, I *will* be happy to have back the five to eighteen hours a week which it took to take care of the duties required of your President. Not that I will now have this many leisure hours, but just that I will be able to have some change of pace and projects. For after all, I never have been, nor perhaps will ever be, the leisurely type.

No, I will be unhappy to lose that certain spiritual uplift which one has when he knows that he is the official and top representative of a group of hardworking men and women whose purpose, dedication, and desire to give service and to improve the condition of their fellow men is in general without its equal in any other profession or walk of life. And I feel unhappy not to be able to continue to project this true image of the medical profession through the Association to our fellow citizens. We have for too long been too quiet about what we are doing and achieving, and our calm self-confidence has too often been interpreted as conceit, when it is really no more conceit than the desire to earn a decent living can be classed as greed.

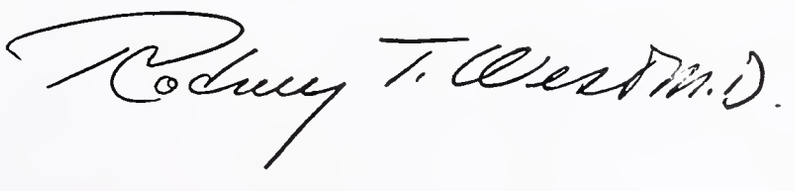
Yes, I will be glad to pass on my duties and responsibilities of office to your new President. Not because I wish to be rid of them—for it was within my power not to accept them in the first place—but because I know that change is always necessary and because I know that your new President has ideas for improving the administrative structure of our medical association. For as Thomas Carlyle said, "Today is not yesterday.—We ourselves change.—How then, can our works and thoughts, if they are always to be fittest, continue always the same?—Change, indeed, is painful, yet ever needful; and if memory have its force and worth, so also has hope." I appreciate the fact that too radical a change, or too rapid a change, before people are ready, can be as disastrous as no change at all, and so I have tried to have patience and to be as cooperative as my principles would permit. And at times, when very frustrated, I have tried to remember that Plato said, "Seven years of silent inquiry are needful for a man to learn the truth, but fourteen in order to learn how to make it known to his fellow men."

I will be unhappy to lose the sounding board for my ideas and ideals which the office of the presidency of this society has offered me. I have used it probably more vigorously than former presidents have, because I have always felt that a president or the head of any organization should not only serve but also lead. Many of you felt that our honest differences of views and honest debate might be interpreted by the public as signs of disunity. However, I am of the feeling that our community has matured enough in the ways of democracy to know that these expressions of differences are the vital processes of policy-making among free men—and realize that doctors like everyone else are searching for new answers not only as scientists but also as citizens. May we never see the day when we elect a president because you know he will be a rubber stamp for the usual and apparently inevitable small group in power! For as Robert G. Ingersoll noted, "The man who does not do his own thinking is a slave, and is a traitor to himself and to his fellow men."

Yes, I am happy to be able to thank everyone who unselfishly participated in the functions of the Hawaii Medical Association and helped me during the past year. Without them the year would have been very drab and unproductive. They are the few who have already found out that to do something for other than your own personal gain is to do the most for yourself. It is too bad that we do not have more of these people who look at the organization as a whole and at the benefits which therefore accrue to everyone, instead of apparently having so many who first want to know, "What's in it for me?"

I am unhappy that I was not able to instill into more of the new members a sense of need for more active participation in the affairs and activities of the Association. I think they do not realize how much time, effort, and money the older doctors and those who have gone before us have put into their medical association. We handed them, probably, too much "for free," and they fail to appreciate and realize that their rights, liberties, privileges and facilities can only be held, and the standards of medical care and a good public image can only be maintained, by constantly fighting and working for them. I certainly hope they will see the light before it is too late. It is very important right now that we stand together and stand up for our rights as doctors, and for organized medicine, which is trying to preserve our right to continue to give our patients—without government interference—the best medical care in the world.

So you see, it is hard to say "yes" or "no" to the question I have been asked. I do, however, leave the office of President with a sense of much relief from the many responsibilities, but with mixed emotions because there were many compensating factors. Again, many thanks to all of you who helped, and thanks for the privilege of helping you and being allowed to better myself!



HAWAII MEDICAL JOURNAL

Editorials

Children's Hospital – Milestone or Millstone?

Competition from general hospitals has reduced bed occupancy at Kauikeolani Children's Hospital to such a low level that the hospital's training program, its educational program, and indeed its very existence, are still in a precarious position, despite the Board's decision to keep it open for the foreseeable future.

The ultimate responsibility for past insufficient use of Children's Hospital belongs to the doctors who send children into hospital beds. However, Children's has not always courted general practitioners and surgeons; it has been the pediatricians' institution first and foremost, and economic realities have in the past been somewhat slighted. The hospital must bear a part of the burden of the responsibility for its present plight. And of course far fewer sick children require hospitalization, these days.

Nevertheless, as Dr. Reppun pointed out in the last issue of the JOURNAL, a high-quality Children's Medical Center, such as this hospital has become through its training and Visiting Professor programs, is a vitally important asset in the over-all health picture in our city. It should be kept going if possible, and if it is still afloat as you read this, then it probably *is* possible.

Two things would go far to make it so. One is to get a fair share of the pediatric indigent care program into Children's Hospital. The other is to get an economically high level of utilization of beds—and *you* can achieve this, Doctor, by *sending your pediatric hospital cases to Children's Hospital.* Make this year a milestone in the hospital's progress instead of a millstone around its corporate neck!

"Probably Benign" Still Equals "Possibly Malignant"

Dr. William Bachrach, a Los Angeles gastroenterologist, reviews in this issue his attempt to identify gastric cancer roentgenologically in 100 consecutive cases of gastric ulcer. Of the 103 ulcers found, he diagnosed 47 as definitely benign and 18 as malignant; 38 were called "equivocal."

All the patients were operated upon. Six in the "definitely benign" group, three in the "malignant" group, and one of the "equivocal" ones, were found to have cancer: a total of ten. Race had nothing to do with the low batting average; the 60 Japanese patients furnished only four cancers, while three occurred among the 13 Caucasians, and three among the "other" ethnic groups. No part-Hawaiians had cancer in this series.

Of the 93 ulcers (in 90 patients) which turned out to be benign microscopically, only 40 had been so identified by x-ray. A positive diagnosis of cancer had been made in 16, and 37 were called equivocal.

With commendable frankness, Dr. Bachrach points out that this might be regarded as a diagnostic error of 70 per cent—since seven of the ten cancers were missed by x-ray. He properly adds, however, that the real level of error is the six cancer cases occurring in the "definitely benign" group of 47 lesions—a level of 15 per cent error.

On the face of it, this means that in unselected cases of gastric ulceration, an x-ray diagnosis of "gastric ulcer, malignant," meant there was one chance in nine the patient actually had cancer; while a report of "gastric ulcer, benign," meant there was a slightly higher risk (one in eight) of malignancy. Only in the "equivocal" category could the patient feel safe, with a risk of one chance in 38 that he had a cancer.

Dr. Bachrach takes these findings as evidence that x-ray examination should be repeated after three weeks of medical treatment; he hopes they will not be used as a basis for "reviving" the idea that all gastric ulcers should be resected. He points out with some reason that this would involve only slightly longer delay than is usual when "immediate" operation is advised and agreed to.

We would go this far in agreement with Dr. Bachrach: in view of his findings, if x-ray examination is worth doing at all in these cases, it had better be done twice. Once, clearly, isn't enough.

Welcome, Dr. Windsor Cutting!

The appointment of Dr. Windsor C. Cutting as Director of the Pacific Biomedical Research Center is welcome news. Dr. Cutting is to assume his new duties in July.

Pharmacology and therapeutics have been Dr. Cutting's principal fields of interest. His graduation from Stanford Medical School in 1932, at the age of 24, was followed by four years' residency in medicine at Stanford, a year in biochemistry at Middlesex Hospital in London, and two years in pharmacology and medicine at Johns Hopkins. He returned to his alma mater, in 1938, to become successively Assistant Professor (and later Professor) of Therapeutics, Professor of Pharmacology, and Professor of Experimental Therapeutics, with a four-year stint as Dean (he resigned this position in 1957) along the way.

In addition to his teaching and administrative responsibilities, Dr. Cutting has served for 12 years on the AMA Council on Drugs (formerly Council on Pharmacy and Chemistry) and for the last five of those years as Chairman of its Nomenclature Committee. For seven years he has been Director of Annual Reviews, for which organization he edited the Annual Review of Medicine from 1950 to 1954, and the Annual Review of Pharmacology from 1961 to the present. He is a member of the Board of Directors of the U.S. Pharmacopeia, and was a member of its Executive and Revision Committees from 1950 to 1960. He has been, since 1962, a member of the Board of Regents of the American College of Clinical Pharmacology and Therapeutics.

In addition to over 200 published reports of research in the fields of pharmacology, toxicology, and endocrinology, Dr. Cutting has published five books, notably *Manual of Clinical Therapeutics* (second edition, 1948) and *Handbook of Pharmacology* (1962).

These are only the highlights of Dr. Cutting's distinguished career. A fellow-professor at Stanford describes him with such phrases as "great integrity, immense kindness, and extraordinary vision . . ." We congratulate the University on its good fortune in obtaining his services for this important job, and we welcome him most warmly to the Manoa campus and to Hawaii!

"Such Steps as They May Elect"

An effort in 1950 to enroll the American Medical Association on the side of integration failed; the House of Delegates chose to leave this question up to individual hospitals and individual county medical societies. A study of the question was urged upon both classes of organizations—"with a view to taking such steps as they may elect to eliminate such restrictive provisions."

A renewed effort to accomplish this end in 1957, by urging all hospitals to delete from their bylaws and rules any provision requiring membership in the American Medical Association or a county medical society as a prerequisite to admission to the hospital staff, was defeated. A southern member of the Reference Committee informed us during the hearing that "we rely on this provision to keep negro physicians off the staffs of hospitals."

In 1963, another drive to enlist AMA support for integration was turned aside with exactly the same weasel words as those employed in 1950; in effect, a simple affirmation of "states' rights."

The British Medical Association some years ago went to court to prevent a labor union from enforcing compulsory BMA membership upon physicians employed in hospitals. Membership in the British Medical Association, the Association insisted, must be voluntary, not compulsory.

It ill becomes the AMA to condone a "closed shop" requirement, to which it is a party by reason of being the organization in question. If the closed shop is wrong for labor unions, and we believe it is, it is wrong for the AMA as well. You can't have your cake without eating it too.

This Is What's New!

• The recent efforts of Jack Ruby's defense to prove that he had epilepsy, with the inference that if he did, he would be more apt to commit murder and, at the same time, not be responsible for the crime, has resulted in a strong editorial protest in the *JAMA*. A Baltimore physician, who writes the editorial, states that during his medical career of living and working with some 1,500 epileptic patients, he has observed no more crimes committed by this group than any other. He also refers to the monograph of the expert, Lennox, who observed that among the thousands of epileptic patients that he had cared for, only one committed murder; and in retrospect, Lennox apparently had doubts about his diagnosis of epilepsy. The Gibbses, also world-famed experts in the field of epilepsy, also stated that none of their patients with psychomotor epilepsy had killed anyone. In short, an epileptic might kill not because he has epilepsy, but because he is a human being. **The epileptic is no more a potential murderer than the so-called normal individual.** (*JAMA* [Apr. 13] 1964.)

• **Villous adenomas** are rare, bulky tumors of the colon and rectum which are covered with **mucus high in potassium.** They are sometimes referred to as potassium-secreting tumors, and they cause severe electrolyte imbalance with hypokalemia. They are also **apt to become malignant.** The treatment of choice is wide local excision. (*Arch. Surg.* [Apr.] 1964.)

• Patients undergoing **splenectomy** for carcinoma of the stomach were **less tolerant** of the **cytotoxic drug,** Thio-Tepa, than those not having splenectomy. Animal studies confirmed the clinical study. Cancer chemotherapists are warned to reduce the dose of anticancer drugs in patients without spleens. (*Arch. Surg.* [Apr.] 1964.)

• **Guanethedine,** more frequently used in the treatment of **hypertension,** is apparently extremely effective in the treatment of **pruritus of atopic dermatitis.** In 19 of 20 patients so treated, itching was relieved. In a double blind study, 11 of 12 patients with atopic dermatitis experienced relief of pruritus while on this drug. (Only 4 of 12 patients using a placebo had similar relief of symptoms.) Conclusion: Guanethedine in a dose of 0.75-1.25 mg/Kg per day is effective in relieving the pruritus of atopic dermatitis and suggests that the disease may be manifestation of a hereditary defect in norepinephrine binding in the skin. (*Canadian Med. Assoc. J.* [Mar. 17] 1964.)

• **Glucose-6-phosphate dehydrogenase deficiency,** referred to in the trade as "G-6-PD deficiency," is a fairly common disorder which is usually asymptomatic unless the patient ingests certain drugs that cause lysis of the G-6-PD-deficient red cells, with resultant **hemolytic anemia.** The defect occurs in 12-15 per cent of male Negroes and, incidentally, has a variable incidence among the ethnic groups of Hawaii. As a rule the red cells, although deficient in the enzyme, do not totally lack it. However, investigators in Chicago report the very rare situation of a Caucasian male with **complete absence** of G-6-PD. In addition to a marked hemolytic anemia, the patient had an unusual neurological disturbance characterized by **epilepsy** and other neurological manifestations. Relatives of the patient had decreased G-6-PD. (*Arch. Int. Med.* [Mar.] 1964.)

• The **house cricket** has daily fluctuation in its **blood sugar concentration.** The authors, supported in this work by NIH Grant G.M.-08862, suggest that other metabolites in insects be studied in a similar manner. (*Science* [Apr. 10] 1964.)

• A Cleveland surgeon gives more statistical support to what an increasing number of physicians believe: **simple mastectomy** is the treatment of choice in **carcinoma of the breast.** Not only is the morbidity less—which is recognized by all—but the **survival rate** following the simple procedure is **equal** to that following radical mastectomy. (Really a bit better in this series.) Old ideas die hard, but all physicians who believe that radical mastectomy is the choice of therapy for carcinoma of the breast should read this article, which, incidentally, is in agreement with earlier similar but retrospective studies. (*Surg., Gynec., & Obstet.* [Mar.] 1964.) ■

FRED I. GILBERT, JR., M.D.

Nearly all hospital medical staff constitutions and bylaws stress the rules and regulations that must be followed if a member is to get on the Active Staff and stay on it. The unquestioned assumption is that the right to vote at medical staff meetings is the ultimate goal.

What is this great privilege which all new young staff doctors are exhorted to attain? What is so desirable about this vote?

ONE MAN, ONE VOTE

A vote has value in any democratic society; it gives the voter the franchise to add weight to his personal opinion on an equal basis with that of his peers. It makes equals of us all, rich or poor, intelligent or ignorant, big or little. The one vote can influence the course of events by making a majority out of an opinion. However, to have this value, the vote must carry equal weight. It loses this value if the ballot boxes are stuffed, if the opposition votes en bloc, or if there is no hope of overthrowing an entrenched opposition.

Too often, in hospital medical staffs, an entrenched clique or oligarchy holds power with a firm grip.

Too often, in medical politics, the rules and regulations are set or are modified in a way to disenfranchise those who may become nonconformists.

Too often is it apparent that the rulings of the JCAH, which are plainly stated to be only guidelines, are interpreted "according to the letter of the law" by entrenched medical staff committees.

It becomes obvious, then, that it is no great privilege to become an active staff member and have a vote that means little, things being the way they are, especially for GP's.

DEPARTMENTALIZATION

Since hospital medical staffs have gone into departmentalization, the GP's participation has dropped to a new low, as far as being members of the active staff is concerned. If the GP joins the GP Department, the attendance required of him is at administrative, not clinical meetings—a boring waste of valuable time. He is nicely sidelined out of the mid-stream of hospital clinical work.

If he joins a clinical department, the GP effectiveness as a group is diluted and scattered.

The medical staff, then, is manipulated by departmental committees: the Surgical Committee, for example, makes it a rule that no GP may "first assist" on his own patient, and this is usually rubber-stamped by the weighted Executive Committee, and slipped by on a quarterly staff meeting agenda without discussion but with a routine vote. Opposition by vote is hopeless. We know!

This is discouraging to the GP, who then comes to his senses and goes on to Courtesy Staff, where he need not be bothered by all this medical politics.

IS THERE AN ANSWER?

There is an answer! We can say to the JCAH: "Thanks for the suggestions, but we'll do it our way!" We can ignore the narrowness of the guidelines.

If every duty had its privilege, to paraphrase a trite saying, then it would entice staff members to become active. The right to vote would become a dividend. If he earned a privilege by working in the OPD, by being a member of the Records Committee, by bringing patients to that hospital, by serving on the emergency roster, etc., he would be much more eager to do those things that a hospital needs to have done without pay.

It is not the vote per se that is the privilege. Once he is given privileges commensurate with his ability, and also the privilege of advancing himself, the young GP on the staff will gratefully and dutifully exercise his vote. As it is now, to threaten a member with the loss of his vote is like Bre'r Rabbit said to Bre'r Fox, "Please don't throw me into that there briar patch."

Privileges should be tied in with duties, As they are defined in most medical staff bylaws at present, the two are entirely separate. Is there any good reason why a hard working, actively participating staff member couldn't be rewarded by extending his professional privileges?

It is not the vote, but the extension of privileges, that should be the goal, to entice members into active staff status. ■

J. I. Frederick Reppun, M.D.
Secretary-Treasurer

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii.....

This is the forty-ninth installment of In Memoriam—Doctors of Hawaii.

Leland Frazier

Leland Frazier, born in 1879, was a graduate in 1906 of the St. Louis School of Medicine.

In 1914 he was in practice at Wahiawa, Oahu. After this nothing can be learned of his whereabouts until 1923 when he is listed in the Medical Directory as being located at Rupert, Idaho, and limiting his practice to roentgenology.

Dr. Frazier died in Rupert on February 15, 1935, at the age of 55.

He was a former member of the Medical Association of Texas.

Arthur Crawford Rothrock

Arthur Crawford Rothrock was born September 13, 1886, at Reedsville, Pennsylvania, the son of Dr. Samuel H. and Mary (Lowder) Rothrock. As a boy he decided to follow in his father's footsteps and become a doctor.



DR. ROTHROCK

He was educated at Reedsville High School, Pennsylvania State College, and at the University of Pennsylvania from which he received his M.D. in 1912. Coming to Hawaii, he served his internship at The Queen's Hospital from 1912 to 1914.

On December 15, 1915, he married Frances Kinney in Honolulu. The couple had two children, Mary Catherine and Arthur.

From 1916 until the time of his death Dr. Rothrock practiced in Paia, Maui. He also served as resident physician for Paia Hospital, a position he held for 32 years.

Dr. Rothrock married Gwendolen von Tempsky Bridgeford on June 29, 1933, at the home of Duncan B. Murdoch who was at that time Justice of the Peace on Maui.

On August 9, 1948, Dr. Rothrock died at his home on Maui at the age of 62.

He was a 32nd Degree Mason, a Shriner, a member of Phi Rho Sigma Medical Fraternity, Maui County Medical Society (President in 1933), Hawaii Medical Association, Maui County Fair and Racing Association, and the Maui Country Club.

Dr. Rothrock was a truly dedicated man, the practice of medicine coming before anything else in his life. An outstanding surgeon, he worked tirelessly, giving of his best to both the high and the low. Many of the hundreds of the plantation laborers who were in his care came to him for help other than medicine, and were never turned away. He was dearly loved by all, and affectionately known as Dr. Rocky.

He had a quiet and gentle personality and a keen sense of humor. His only hobby was buying beautiful rugs and furnishings for his home. He loved to dance and was an excellent tap dancer.

MRS. ARTHUR ROTHROCK

Edgar Nelson Young

Edgar Nelson Young was born in San Diego, California, on July 21, 1885. The family of brothers and a sister early lost their parents.

Coming to Honolulu in 1904 to join his brothers, Will, John A., and Herbert, Edgar attended McKinley High School. In 1912 he graduated from the College of Physicians and Surgeons in Los Angeles.

About 1914 Dr. Young returned to Hawaii to become physician for the Hawaiian Commercial and Sugar Company at Puunene, Maui. Later he also served as physician for the Kahului Railroad Company. Sometime in 1918 he moved to Lihue, Kauai, where he was government physician. In 1921 he moved to California locating in San Diego where he established a practice which eventually was limited to proctology.

Dr. Young was married and the father of two sons, Bill and Nelson.

On December 23, 1943, Dr. Young died in San Diego at the age of 58.

He was prominent in the Shriners and Scottish Rite. Formerly he was a member of the Hawaii Medical Society. ■

HAWAII MEDICAL JOURNAL

Bureau of Medical Economics

One of the most difficult areas in the field of medical practice is the one where the words "legal procedure" arise, and while there are very few cases of this nature, it must be admitted that litigation is undertaken by collection agencies from time to time as the only recourse pertaining to a delinquent medical account.

It must be stressed at this junction, however, that this is done only after every conceivable effort to collect has failed and after stringent inquiry has assured us that: (a) It is a genuine debt in every respect, (b) The debtor is in a financial position whereby the account could be met, and (c) Such litigation will not affect the debtor's employment in any way whatsoever. Only after having ascertained these facts will a reputable collection agency set their legal machinery in motion.

With the inauguration of this machinery, several things must happen. First, the agency must get the doctor's permission to file legal suit. The agency usually sends to the doctor's office a suitable form which the doctor personally signs and returns to the agency. At the same time a copy of this form is sent to the debtor, so that he can see that such an action is about to be instituted. In passing, it is interesting to note that on receiving a copy of "Order to File Suit," in many cases, the debtor settles the account, not wishing to face the embarrassment of a court action, plus the thought of legal charges added to an already overdue account.

In such cases of litigation, the doctor has a definite responsibility. In most cases the collection agency's attorney will need an itemized statement. Procuring such a statement is, in many cases, one of the greatest headaches in the collection business. To get such a statement from many medical men is like extracting teeth from a hippopotamus. From the time of filing papers in the court to the actual hearing is approximately two weeks, and in this time, all papers have to be ready for the hearing. Granted, most medical men are aware of this responsibility and prepare and forward all documents requested of them. There is, however, the other type. I refer to the medical man who is "too busy." Gentlemen, there are many of you around these fair islands that fit this bill. Collectors and attorneys too are busy people, far too busy to contact a doctor's office as many as four or five times in an attempt to get essential documents.

After procuring these papers, an agency often finds that they are completely useless, as in many cases they are written in longhand and are illegible, or they are typed at the doctor's dictation, leaving out dates of service, type of service, and in many cases (when an entire family is involved) to whom the service was rendered. Many medical men are deplorably lax in the matter of their responsibilities toward the person who is attempting to facilitate the collection of the doctors' accounts. It must be realized that legal procedure is involved, and the doctor is as much a part of the case (although he is rarely present) as the people who are acting in his interest. It is the duty of the doctor to make his secretary aware of the importance of such documents. If the doctor treats the subject lightly it follows that his hired help will adopt the same attitude.

One of the basic disputes, or one should say one of the excuses, for nonpayment, is the question of fees, and although disputation concerning this is often the given reason for nonpayment, this is merely an excuse. Therefore, one of the tasks of the physician is to be certain that whosoever is representing him has the correct type of proof of service on statement. Most people outside the medical profession are ignorant of medical economics, so be sure to state for whom the money is charged, the specific treatment for which it is charged, and the date when the service was rendered.

In conclusion, it is wise to bear in mind that the presiding judge often examines the statement in question, and anyone who has had experience with the bar knows full well that anything tendered as written evidence has to be perfect in every detail. Therefore, next time you get a request from your collection agency for an itemized statement, please see to it that it is produced with all the speed and correctness possible, so that your interests can be facilitated. ▪

GABRIEL ROGERS
Manager

HAWAII MEDICAL JOURNAL

Book Reviews

Guides to Psychiatric Rehabilitation

Edited by Bertram J. Black, 81 pp., $2.50. Altro Health and Rehabilitation Services, H. Wolff Book Mfg. Co. Inc. 1963.

THIS PAPERBACK MANUAL reports on the three-year experience of a multiservice rehabilitation team working in a mental hospital ward (Rockland State) and a community workshop (Altro of New York City) with the aid of vocational counselors (State DVR) and Aftercare Clinic. They dealt with mostly psychotic patients, about 75% of 261, with 55% schizophrenic. Although measured results could not be determined, the program has been extended to two other wards. Some 10% of a ward of 300 patients can be expected to be unsuitable, but about 70% will respond favorably. Assessment of ability to work under the circumstances was hampered by overprotection, limited hours and lack of pay, but 63 patients were placed in jobs or sheltered workshops after discharge. In the main, the project demonstrated the practicality of such a program and particularly the value of vocational rehabilitation counselors in a mental hospital setting. The booklet is highly readable and offers numerous, illuminating case histories.

J. KENDALL WALLIS, M.D.

★Surgical Pathology, 3d Ed.

By Lauren V. Ackerman, M.D., and Harvey R. Butcher, Jr., M.D., 1244 pp., $18.75, The C. V. Mosby Company, 1964.

THIS IS THE STANDARD TEXT in the field of surgical pathology, and it deserves to be. It is useful throughout the entire spectrum of skills in this field. The third edition adds 148 pages to the second and the ultrastructural illustrations are particularly welcome academic additions. The high quality of all illustrations is maintained. As the field of surgery expands, a text of surgical pathology must evolve into a text of general pathology. It seems likely that the fourth edition will appear in two volumes and have a much more extensive section on cardiac pathology, which is given far less attention than it deserves in the present edition. This text is highly recommended to both surgeons and pathologists.

GRANT N. STEMMERMANN, M.D.

Surgical Gynecology, 3d Ed.

By J. P. Greenhill, M.D., F.A.C.S., F.I.C.S. (Hon.), F.A.C.O.G., 368 pp., $9.50, Year Book Medical Publishers, Inc. 1963.

THIS IS THE LATEST edition of this handbook of operative gynecology. For its compact size, it is very complete, profusely illustrated with many step-by-step diagrams covering all the minor and major operations used by well rounded obstetricians and gynecologists. In addition, in the descriptions alongside, Dr. Greenhill has continued to drop "pearls" and warn of pitfalls in the various procedures. He has enlarged it to include newer surgeries popularized since the last edition. As in the past, he emphasizes total care of the patient with the all important pre- and postoperative care.

While it will not replace the lengthier and bulkier text books, it serves the same purpose—that of easily and quickly refreshing the memory in details of operative procedures; and it is much more portable.

ARNO MUNDT, M.D.

★ means highly recommended.

★Anesthesia for Surgery of the Heart, 2d Ed.

By Kenneth K. Keown, M.D., F.A.C.A., 206 pp., $7.75, Charles C. Thomas, 1963.

A REVISED second edition of a successful text book is usually looked forward to with great expectation. This is especially true of Dr. Keown's monograph since he is one of the pioneers and also is still [at the advanced age of 47—ED.] contributing to the literature in this branch of anesthesiology. The subject matter has been rewritten and updated since the 1956 edition. Illustrations have been enlarged and new ones added. Certainly the inclusion of several chapters by other physicians knowledgeable in this highly specialized field has enhanced the practical value of the author's work.

Outside of several annoying misspellings (vegal for vagal p. 78, atrophine for atropine p. 96, acepted for accepted p. 97, oarta for aorta p. 109, etc.) which incidentally, did not appear in comparable sentences in the previous edition, the publishers did an excellent printing job. The paper is far superior to that of the first edition.

This monograph is a handy reference guide particularly for those anesthesiologists who are not giving anesthetics for cardiac surgery every day. It will also be of value to other physicians and students interested in the anesthetic management of patients undergoing cardiac surgery.

GEORGE F. PARKER, M.D.

The Biochemical Diagnosis of Heart Disease

By Clarence M. Agress, M.D., F.A.C.C., F.A.C.P., and Harley M. Estrin, M.D., 173 pp., $7.75, Charles C. Thomas, 1963.

THIS ATTRACTIVELY printed, well-written book is designed to help the clinician select laboratory tests appropriate for the diagnosis of heart disease. The book is divided in two parts: The first concerns the use of enzymes in the diagnosis of heart disease; and the second, other biochemical tests in heart disease.

The handling of the problem of enzymes is written with a view to the clinician and his interests although the historical development and the biochemistry involved are well presented. An extensive review of the literature is obvious from the discussion. The second part of the book is somewhat less stimulating primarily because material discussed is not quite so new and therefore better known by most of us. Nevertheless, it too is well presented. A very useful appendix is included with tables of normal values, fluid and electrolyte values, and procedural techniques clearly defined.

While in general the book is quite useful, it suffers primarily from the fact that the material which is most interesting, i.e. the enzyme discussion, is rapidly changing, and it can be seen that already, even though the book was published in November, 1963, new developments are in the literature which do not appear in this book, such as organ-specific enzyme differentiation, and so forth. Nevertheless, the reviewer feels it is a useful and meaty manuscript.

E. L. CHESNE, M.D.

★Diseases of the Chest, 2d Ed.

By H. Corwin Hinshaw, M.D., Ph.D., D.Sc., and L. Henry Garland, M.B., B.Ch., M.D., 798 pp., $20.00, W. B. Saunders Company, 1963.

THERE ARE FEW AREAS in which medicine has advanced as rapidly in recent years as in the diagnosis, physio-

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Maternal Death Study

This almost-40 primigravida first saw her physician during her 20th week of gestation, and was referred to a health center during the 25th week. No nausea, vomiting, or any unusual complaints were reported in the first trimester. The public health nurse gave her diet instructions. General physical examination was not remarkable. Pelvic examination was omitted "because she was pregnant." Only the external conjugate and the bi-ischial diameter were recorded, at 18+ and 19+ cm respectively. Serologic test for syphilis was negative, hemoglobin was 70%. She was given her first polio inoculation.

She was seen at the health center in the 28th, 31st, 38th, and 40th weeks of gestation; urinalysis was negative for sugar and albumin each time. Fetal heart tones were regular and in either the right or left lower quadrant. Weight gain was satisfactory except for a 10-pound gain at the 31st week. She was advised to restrict her intake of sweets.

ANTEPARTUM COURSE

The patient was hospitalized during the 41st week of gestation with uterine contractions occurring at 15-minute intervals; they had started eight hours prior to admission. Physical examination was unremarkable. Blood pressure was 130/50. Urinalysis was normal. External pelvic measurements were taken; external conjugate 17+ cm, outlet 10+ cm, intertrochanteric 29 cm, spines 25 cm. Fetal heart tones were heard in the left lower quadrant at 148 per minute. The fetus appeared to be full term, in LOA position. X-rays taken on admission and read four days later by a visiting radiologist showed a "marked increase in angulation between fetal spine and fetal skull probably due to uterine fibroids." On admission the white cell count was 15,400 with 86% neutrophils and 14% lymphocytes; hemoglobin was 12.6 gm/100 ml, and packed cell volume was 40 vol %.

Twelve hours after admission (and 20 after onset of labor), contractions had increased to every five minutes and lasted about 40 seconds. She received 10 mgm of vitamin K and 0.1 gm of secobarbital (Seconal). Rectal examination after 17 hours of labor showed the cervix to be dilated to 2 cm and the station to be 0 to +1. Ten hours later the membranes ruptured. Rectal examination now disclosed complete dilatation of the cervix, and station +1. Demerol 50 mgm and Phenergan 25 mgm were given.

DELIVERY

At this time, almost 28 hours after onset of labor, forceps application was attempted under local anesthesia, without success. Nitrous oxide and oxygen produced insufficient relaxation, so ether was given as well, following which a viable infant weighing 6 pounds 8 ounces was extracted after bilateral episiotomy.

The infant was in poor condition. Meconium was aspirated from its nasopharnyx, an intratracheal tube was inserted by the anesthetist, and mouth-to-mouth resuscitation was performed.

POSTPARTUM COURSE

Profuse hemorrhage occurred during delivery and afterward; the attending physician estimated blood loss at 1,500 cc. Lacerations were sutured within 40 minutes after the delivery. Blood pressure fell to 48/30 and pulse rose to 140 within the first 15 minutes after delivery, and blood pressure remained around 35/20 for the next hour, during which time the patient received intravenously 300 cc of normal saline solution and 1,000 cc of blood. She was also given 1 cc of Ergotrate, 1 cc of Pitocin, 10 mgm of methamphetamine, and 2 mgm of Neosynephrine.

The patient was returned to the ward at 6:30 PM with a blood pressure of 92/60, respirations 24, and pulse 100. She was still oozing blood, and within half an hour had saturated three perineal pads. A third unit of blood was started at 7:00 PM. Dyspnea persisted, and the skin was cold and clammy. By 8:30 PM, blood presure was no longer obtainable, though only one additional pad had been saturated. The patient expired at 9:15 PM.

AUTOPSY FINDINGS

The final autopsy diagnoses were: (1) Laceration of the vagina and cervix with extension into the base of the broad ligament; (2) Amniotic fluid embolism; (3) Myoma of the uterus; (4) Pulmonary tuberculosis, healed and active.

CONCLUSIONS AND RECOMMENDATIONS

The Committee agreed that the death was directly obstetrical and preventable. Contributory factors were failure to obtain adequate prenatal care, error in professional judgment, and failure to obtain consultation.

All pregnant patients should have a complete physical examination including pelvic examination which includes speculum examination of the vagina and cervix, a bimanual examination, and internal pelvic measurements. Cytologic smears should be taken from the cervix and the posterior pool of the vagina.

Elderly primigravida should be of unusual concern to the attending physician; these patients do not tolerate labor as well as younger women.

The attending physician should look at the x-ray films of the fetus and pelvis himself instead of relying on a visiting radiologist.

Vaginal examination should be done to check the progress of labor in a patient in labor for over 18 hours; rectal examination alone is insufficient.

When a patient is severely lacerated during delivery, she should have her entire birth canal, including the upper reaches of the vagina, cervix, and the uterus, examined adequately to estimate the extent of the damage. Any lacerations should then be sutured as rapidly as possible, to control blood loss.

Consultation should be obtained as soon as any difficulty is encountered during an obstetrical delivery, without waiting until irreversible difficulties have arisen. The members of the Committee are always available for this purpose. Emergency transportation can be arranged if necessary. ■

MATERNAL & PERINATAL MORTALITY
STUDY COMMITTEE

HAWAII MEDICAL JOURNAL

New Members



William Oswald Kirker, M.D.

1313 So. Beretania Street
Honolulu, Hawaii 96814
GENERAL PRACTICE
University of Michigan, 1960
Internship: The Queen's Hospital



Henry Hung Chong Fong, M.D.

1415 Kalakaua Ave., Suite 210
Honolulu, Hawaii 96814
INTERNAL MEDICINE
University of Oregon Medical School, 1957
Internship: District of Columbia General Hospital
Residency: Veterans Administration Hospital, Los Angeles
Postgraduate Medicine—UCLA Medical Center

County Society News

Honolulu

Approximately 248 members attended the February 4 meeting to hear Dr. Virginia Apgar discuss "Early Diagnosis of Congenital Defects." After the scientific part of the program the following new members were introduced: Drs. Richard W. M. Dang and John C. Roberts. Mr. John Pompelli of the AMA spoke briefly about his work and the first reading of the proposed bylaw changes was given by Dr. Carl Lum.

Approximately 250 members and guests were present at the March 3 meeting when Mrs. Anna Engel Rang, Secretary of the American Medical Society of Vienna and known as "Angel" to American medical students in Vienna, was honored.

The following new members were introduced: Drs. Willard Y. Miyahira, J. Kendall Wallis, and Ghim Leong Yeoh. Announcements included the information that the position of Assistant Medical Director at HMSA was open and interested persons were asked to appy. Dr. Berk asked the private physicians to cooperate with the Hawaii Cardiovascular Study which is making a study of Hawaiian and Japanese males.

Proposed amendments to the Bylaws involving changes in membership classifications were presented for vote. Dr. Ando protested the elimination of the provisional membership classification and moved that consideration of the proposed changes be postponed indefinitely. The motion failed to carry. Dr. Arnold, Jr., proposed as an alternative that the provisional membership classification be reduced from three years to one. He moved that consideration of this portion of the Bylaws be deferred to the next meeting. The motion carried.

The meeting closed with a panel discussion on "Subject of Mutual Interest—HMSA" moderated by Dr. O. D. Pinkerton. Discussants were J. R. Veltmann, Albert Yuen, and Dr. Verne C. Waite.

Kauai

Guests at the March 17 meeting included Drs. Oscar Auerbach, James Raleigh, and Joseph Battista. The Treasurer reported that all 1964 dues had been paid. A letter from HMSA advised that the position of Assistant Medical Director was vacant and that applicants were being solicited. A letter from Dr. T. Nishigaya thanked Kauai doctors for their support and advised that his name had been withdrawn. It was voted to notify HMSA that Kauai had no nominations to make. The members were reminded that Mr. Veltmann would attend the April 7 meeting.

Senator Miyake wrote to advise that he was submitting to the State Legislature a bill (SB-239) proposing temporary licensure. This was a result of the meeting the Society had with the Kauai legislators. Dr. Wade advised that the Council voted to oppose temporary licensure as proposed this session.

A resolution supporting Dr. Peter Kim as hospital superintendent at Samuel Mahelona was passed and a copy forwarded to the ILWU and the hospital Board of Trustees. The members voted to appear in court to support Dr. Kim.

Discussion of a coroner for Kauai was postponed pending the arrival of a full-time pathologist. A complaint relative to a physician's alleged refusal to care of a patient was reviewed. The Society voted to ask the person making

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HAWAII MEDICAL JOURNAL / Hawaii Medical Association

MINUTES OF THE COUNCIL MEETING

March 4, 1964, at 6:00 P.M.
Oahu Country Club, Honolulu

PRESENT

Dr. Rodney West, presiding; Drs. Allison, Andrews, Chinn, Fong, Giles, Lum, Miyamoto, Nishijima, Pinkerton, and Wade, plus guests Drs. Richardson and Fleming, county society presidents, and Mr. H. Tom Thorson.

MINUTES

The minutes of the January 29, 1964, meeting were approved as circulated.

SECRETARY'S REPORT

The Secretary's Report was noted as circulated and there were no comments.

ACTION:

It was voted to accept the Secretary's Report.

TREASURER'S REPORT

There were several questions asked about the report of the Treasurer. Dr. Richardson was asked about the basement. He advised that the HCMS Finance Committee had a meeting scheduled with the Mabel Smyth Board for March 5. He said there was nothing new to report and that right now they seem to be very comfortable. Dr. Allison asked if the Association were expected to make any decisions. Mr. Thorson said the meeting is scheduled more or less to outline the ground rules for further discussions. There have been no discussions between all three parties in recent months. The whole thing needs to be reviewed. No conclusion has been reached. It was noted that the Association is still holding $30,000 for this purpose, but no one has been designated to control the financing.

The matter of referring the budget direct to the House of Delegates was discussed. Dr. West said there may be another Council meeting the second week in April and asked that this date be held open. It was pointed out that unless the Annual Meeting receipts and the funds expected from activities of the Convention and Seminar Committee are up to expectations, the financial outlook will not be good.

ACTION:

It was voted to approve the Treasurer's Report.

COMMITTEE REPORTS

Arrangements: Dr. West advised that the Council approved the HCMS Auxiliary's request to combine their AMA-ERF party with the annual banquet and the Arrangements Committee concurred. However, because of some adverse reactions on the part of some of the doctors, the Auxiliary decided to withdraw its offer to help. Dr. Richardson said that he understood that some members were opposed to the idea and they got in touch with the Chairman of the Advisory Committee to the County Auxiliary. The women did not feel that they should do something for a group that did not appreciate what they are doing. Dr. West said he was sorry there was so much dissension after the official action was taken.

Awards: Dr. Giles elaborated on the report and advised that it may be necessary to deviate from the recommendations of previous committees. He noted that selection criteria had not been set up by the Council or House of Delegates.

Careers: It was noted that the Second Annual Careers Day program held on February 21, 1964, was very successful. Dr. Wade advised that the students from Kauai who participated were left with a favorable impression. It is hoped that students from other neighbor islands will be able to participate in the Third Annual Careers Day program.

Convention and Seminar: It was noted that Dr. John Felix agreed to stay on the committee as chairman until June, 1964.

There was discussion about whether or not this committee should be a profit-making enterprise or a community service project. It was noted that this could perhaps be a profitable enterprise if it were known on the mainland that the committee is available to help in making arrangements. It was noted that the primary aim of this committee is to help those groups coming to Hawaii. It was suggested that this committee set up a policy so that there will be no question about charges for this type of service. The travel bureau's financial interests were discussed. Dr. Richardson suggested that we put in writing that we want 50% of the registration fee or a $25.00 minimum. It was suggested to refer this matter back to the committee and have them try to set up a policy and then report back to the Council.

ACTION:

It was voted to tell the Convention and Seminar Committee that there should be more restriction about groups coming to Hawaii and that a policy should be set up.

Chronic Illness & Aging: Dr. Robert Mookini is chairman. A meeting of the subcommittee to report on medical care of the indigent has not been set up yet.

Heart Committee: This committee approved the showing of the film "Pulse of Life" to Medical Self-Help classes.

Legislative Committee: The Legislative Committee report was circulated and reviewed. There was considerable discussion about Dr. Bernstein's bill to permit temporary licensing of unlicensed doctors for emergency areas. Dr. Miyamoto stated that their county society has approved unlicensed doctors practicing in rural areas. Dr. Wade stated that if a doctor is qualified and has been licensed in another state then his county society approves. On the other hand, physicians on Kauai do not approve of a doctor who is licensed to practice in a foreign country. Dr. Andrews stated that Hana is the area which needs physicians. The problem there relates to finances as well as isolation. Dr. Allison felt that Dr. Bernstein's proposal is not an urgency bill and that in case of any emergency, there are several doctors who have Hawaii licenses who are not practicing in Hawaii. Dr. Allison stated that it would be better to add attractions to make rural practice more attractive to these men. If recruiting has to be done, it would then be easier to draw physicians in case of an emergency. There is a residence waiver clause, and it has been used in the past. Dr. Fleming asked if Dr. Bernstein's proposal is to help the doctors or to help the patients. It was asked whether or not this was urgent or merely to get the public health director off the hook. Dr. West felt that we should not oppose Dr. Bernstein's proposal but that we should tell the Legislative Committee to hold up on the bill.

ACTION:

It was voted not to endorse the Legislative Committee's action relating to temporary licensure.

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NILS PAUL LARSEN, M.D.
1890-1964

On March 19, 1964, Doctor Nils Paul Larsen died of a final myocardial infarction, after having suffered an unknown number of such attacks since 1941. His death removed a colorful figure from the local, national, and international scene.

Dr. Larsen was born in Stockholm, Sweden, on June 15, 1890, and came to this country at the age of three. He automatically became an American citizen by the naturalization of his father. Thereafter, he grew up as any American boy, attended the public schools in Bridgeport, Connecticut, and later graduated from the Massachusetts Agricultural College.

After his graduation from college he went to the Medical College of Cornell University in New York City where he received his M.D. in 1916. He served his internship at the New York Hospital (Cornell), and had advanced to the position of Assistant Pathologist when he went overseas with the 106th Infantry in May, 1918. For gallantry in action with that group, and inspiration of others in his regiment, he was awarded the Silver Star.

At the end of the war he returned to Cornell Medical School and became an Instructor in Medicine under the leadership of Dr. Russell L. Cecil and Assistant Visiting Physician in Pediatrics at the Gouverneur Hospital and at Bellevue Hospital. There he engaged, with Dr. Cecil and others, in research on pneumonia and asthma.

In the summer of 1919, he came to Hawaii to visit his elder brother David, who was working here in the sugar industry with HSPA (and later with C. Brewer & Co.). At this time he met Miss Sara Lucas, a friend of the David Larsens. In 1921, she went to New York, where they were married. They returned to Honolulu in July 1922, when he became pathologist at The Queen's Hospital; shortly thereafter, he also became the Medical Director, a post which he held until mid-1942, when he was forced to resign because he was ill on the mainland following further myocardial involvement.

After he arrived in Honolulu and began his association with The Queen's Hospital he continually strove to improve the standards of teaching there, and he organized and conducted the Thursday morning clinics, which became internationally known. He became intensely interested in school health programs; medical care of plantation workers; studies in dental caries, poison spiders, and fish; improvement of milk supply and decreasing infant mortality; and the study of Hawaiian lore and medical practices. He likewise was very active in the work of the Boy Scouts and was instrumental in organizing The Explorer Group of Boy Scouts oriented towards medicine. He was also a Member of the Executive Board, and a past chairman of the Lunalilo District. In January, 1964, he was given the Silver Beaver award by the National Council of Boy Scouts of America, the highest award given to a volunteer worker. The new building, at the Pupukea Camp, is being dedicated in his memory.

His realization of the importance of Hawaii as a connecting link between Occident and the Orient caused him to work vigorously with Dr. George Swift of Seattle and the famous layman, Alexander Hume Ford, in organizing the first Pan-Pacific Congress. This group was then joined by Drs. F. J. Pinkerton and Joseph E. Strode in starting the Pan-Pacific Surgical Association. He was also very active in the Hawaiian Academy of Science and the Institute of Pacific Relations.

In May, 1934, Dr. Larsen joined with Drs. J. R. Judd, F. J. Halford, A. V. Molyneux, and R. J. Mansfield to form The Medical Group.

Aside from his vigorous activities in the medical field, he somehow had time to do some of the earliest underwater photography, and developed skill in color etching and oil painting. As an extensive world traveler, his flair for the dramatic allowed him to take interesting and unusual pictures of places and people, which he generously shared with all groups here, and he was famous for the skillful arrangement and presentation of his programs. He also wrote and produced pageants portraying the history of Hawaiian medicine and the development of The Queen's Hospital for its centennial celebration.

Dr. Larsen was very active in, and was one of the earliest Fellows of, the American College of Physicians; he served as Governor of the College for Hawaii from 1949 to 1958.

Dr. Larsen's interest in public affairs also resulted in his election as a Member of the Constitutional Convention of Hawaii in 1950, in preparation for Statehood, drafting of the Constitution for the State of Hawaii.

Among his many appointments and recognitions have been: Medical Advisor to the HSPA since 1930; decorations by the Governor of New York, the King of Cambodia, and the King of Sweden, in recognition of his personal accomplishments as well as for acting as Vice Consul for Sweden from 1930 to 1942; an honorary degree of Doctor of Medicine from the ancient University of Lund in Sweden; the Order of Merit from the Boy Scouts of America; the Gold Headed Cane award from the University of California for exceptional community service; the William S. Knudson award for community service in the field of industrial medicine; and an honorary degree of Doctor of Science from the University of Massachusetts.

Although he retired from an intensely active practice at the age of 65, he still continued, until the day before his death, to see private patients three or four afternoons a week; continued with his work at the HSPA and edited the *Plantation Health Bulletin;* and continued his active association with the Territorial Association of Plantation Physicians, now known as the Hawaii Industrial Medical Association.

Dr. Larsen is survived by his wife, Sara Lucas Larsen; a son, Jack Lucas Larsen; a daughter, Mrs. James F. (Lila Elizabeth) Morgan, Jr., and several grandchildren. All his patients, nonmedical friends, and fellow physicians internationally and nationally, regret the passing of this amazing figure, who had so many facets.

This rather inadequate summary of the life of a truly great man is humbly submitted by one who knew him first when the writer was a sophomore medical student and later knew him as a great teacher, and following that as a partner and great friend.

ARTHUR V. MOLYNEUX, M.D.

HAWAII MEDICAL JOURNAL

Notes and News

New Office for . . .

Dr. Henry H. C. Fong, who has announced the opening of his practice in internal medicine at King-Kalakaua Building.

Happy Notes . . .

You have doubtless heard of "fractured French," i.e., a group of silly translations and definitions for common French phrases, such as "pièce de résistance," meaning "shy girl." There is a parallel category which might be called "mangled medicine." **Dr. Claude Caver** gave us a few illustrations of this sort of madness: deep plantar = potato farmer; psoriasis = tender buttocks; vasoconstrictor = "What kind of snake?"; debridement = divorce after the honeymoon; femoral annulus = lady commentator; intestinal grippe = a wrestling hold; descending colon = typographical error; photosensitive = camera shy; globus hystericus = planet Earth.

Opening their homes for civic benefits were **Dr. James Harrison,** who entertained the opera and symphony crowd, and **Dr. Niall Scully,** at whose home the St. Francis Hospital Auxiliary met.

Health Tips in the News . . .

For some unaccountable reason, island children are hit with a mumps outbreak about every three years, according to **Dr. William E. Lyons,** State Epidemiologist. In January, there were 538 cases; in February, 498. Ordinarily, the average is about 70 cases a month.

Out of the 60,000-plus returns from physicians reporting on their smoking habits, *Modern Medicine's* survey indicates that four-fifths of those answering have smoked at some time in the past. At present about half of all M.D.'s do not smoke, indicating that a significant number have given up the habit.

"Caution" labels on every pack of cigarettes, with a notation that cigarette smoking is dangerous to health, was the advice of **Dr. Leo Bernstein,** Hawaii's Public Heath Director. It's up to the Federal Trade Commission now.

The T.B. and Health Association of Hawaii County has donated $3,105 from Christmas Seal funds, toward purchase of a new mobile x-ray unit for the Big Island. The 1962 Legislature appropriated $40,000 for this purpose, but by the time bids were called, the price had gone up. **Dr. Henry Bockrath,** Hawaii County Health Officer, feels they may have enough for the purchase now.

Generous Philosophophiles . . .

Doctors are not noted for their generosity in contributing to community campaigns for funds. All the more credit, therefore, to the two medical groups and six individual physicians, out of 95 donors (mostly corporations) who gave $1,000 each to help finance the Fourth East-West Philosophers' Conference: **Chock-Pang Clinic, Medical Specialty Clinic,** and **Drs. Abraham Ng Kamsat, David Lee Pang, Richard Y. Sakimoto, K. S. Tom, Raymond C. Yap,** and **Richard You.**

Placement Service . . .

A locum tenens is available in the Pearl Harbor area for a GP for one to two months, starting about June or July. Locum tenens and permanent positions are available on all islands, including Johnston. A Japanese speaking associate is needed in California. Call Lee McCaslin for details.

ARTHUR L. DAVIS, M.D.
1884-1963

When Dr. Arthur L. Davis died of a brain tumor on October 20, 1963, Hawaii lost one of its most respected and dedicated physicians. While in active practice, he lived and breathed medicine to the almost total exclusion of everything else, and although retired for some eleven years, he would often think of some of his old patients and call to ask how they were getting along.

Dr. Davis was born in Keysworth, Nottinghamshire, England, on August 17, 1884. He was graduated from the University of Illinois Medical School in 1914, and held a residency at Michael Reese Hospital, Chicago, from 1914 to 1916. He spent the following year as resident surgeon at Lord Lister Hospital in London.

He was a Captain in the Medical Corps, stationed at Schofield Barracks, from 1917 to 1919.

Following his term of service in the Army, he went into private practice in Honolulu prior to joining the Waialua Agricultural Company as its Medical Director on May 14, 1927, retiring on July 1, 1952, after 25 years service.

Besides his work for the plantation and for his private patients, Dr. Davis found time for various activities. He was an active, dedicated Mason, and his honors included past Master of Hawaiian Lodge No. 21, F. & A. M.; past Master of the Consistatory; past Sovereign of the Red Cross of Constantine. He was active in Scottish Rite, and was coronated a 33rd degree Mason in 1949.

He was a charter member and past president of the Wahiawa-Waialua Rotary Club.

Dr. Davis was noted for his hobby of woodworking, conducted in his own shop, where he made and finished many beautiful pieces, including several for the then new St. Stephen's Episcopal Church.

Surviving are his wife, Rose, and two sons: Francis, an interior designer in Honolulu, and the famed singer, Charles K. L. Davis.

FRANK H. HATLELID, M.D.

Names in the News . . .

Dr. Min Hin Li played host to 77 University of North Dakota alumni during their four-day stay. Local alumni hosted a dinner at Lau Yee Chai for the group.

Dr. O. D. Pinkerton made the point that the establishment of a two-year medical school at the University of Hawaii is unwarranted because the base of our tax structure is not broad enough to support such a financial burden. According to U.H. Vice-President Robert Hiatt, Hawaii's share would be about $390,000 yearly.

The "Angel of Austria," **Mrs. Anna Engel Rang,** visited here in January to renew friendships she has made with 30 Honolulu doctors, whom she had helped on their European sojourns.

The World Adventure Tours, formerly run by the Kiwanis Club, will now be sponsored by a new citizens' committee, doctor-members of which include **John Devereux, Howard Liljestrand, R. Varian Sloan** and **Rodney T. West.** The season will open in October, with Thomas L. Schmidt's presentation of "Hong Kong."

Dr. Robert Chung has announced that the Castle Memorial Hospital will in future follow public relations policies practiced by other hospitals in Honolulu; e.g., information relating to age, sex, address and condition of accident victims will be available to the news media.

Community Chest funds for Community Associations will be phased out by June, 1965. This action came on the heels of a letter written by **Dr. Fred Reppun,** who thought it high time the Chest stopped subsidizing these associations.

Dr. Peter Kim, the part-time Health Officer on Kauai, was challenged in court by a former candidate for the Board of Supervisors. It was alleged that Dr. Kim performed other work than that which was his responsibility during the regular working hours of Samuel Mahelona Memorial Hosptial, where he is superintendent. Dr. Kim denied that his other duties interfere with his job at Mahelona.

Dr. Grover Batten's home was entered by a burglar at 2 A.M. The doctor heard the intruder and gave out with a loud yell, that made the criminal run out, stumbling over a potted plant as he got away.

A front-page story, charging "extravagance" at Leahi Hospital, appeared locally. **Drs. Theodore Tomita, George Mills** and **R. Frederiek Shepard** gave testimony to a House-Senate committee on the alleged "top-heavy staffing" and "conspicuous dispersal of patients." Among those cut so far are **Drs. Homer Iznmi, Carl Mason** and **Bernard Yim.**

Drs. Robert H. Moser and **Willis Butler** (nicknamed "Red" Butler by his acquaintances on Molokai) locked horns in the "Letters to the Editor" section of the local press. Dr. Butler wants U.S. to pull out of Vietnam and accept "neutralization" of that area. Dr. Moser feels these are "asinine thoughts."

Dr. T. W. Kanda, government physician for the Wailuku district, has retired after 32 years of faithful service; reason: poor health. **Dr. Kenneth Haling** will replace him.

Dr. Marion Hanlon has been appointed chairman of the Mental Health Task Force Steering Committee on Maui. Another physician on the committee is **Dr. Edmund Tompkins.**

Dr. Nils P. Larsen, 73, died of a myocardial infarct at Queen's Hospital March 19. A great teacher, a superb organizer, and a most pleasant person to talk to, he will be missed.

Dr. Cora A. Manayan was featured in the "Career Women" section of the Star-Bulletin. The ob-gyn doctor's life was traced from humble beginnings in the Philippines to her present position in the Honolulu and Waipahu clinics, which she shares with her brother, **Dr. Henry Manayan,** currently at Kaunakakai.

The 1964 polo season officially opened in March. **Dr. Masato Hasegawa** rides again!

Dr. Vernon Boido has been appointed to the Kauai School Advisory Council. He is in private practice at Koloa.

Newly elected Fellows of the American College of Obstetrics and Gynecology are **Drs. Murray S. Berger** and **Theodore Tseu.**

Hawaii Department of Public Health

COMMUNICABLE DISEASES IN HAWAII
February-March 1964

DISEASE	FEBRUARY 1964	MARCH 1964	MEDIAN FIVE-YEAR
Chickenpox	159	194	106
Conjunctivitis, Infectious	2	—	1
Dysentery, Amebic	—	—	<1
Dysentery, Bacillary	17	2	10
Gonorrhea	39	72	19
Hansen's Disease	1	1	1
Hepatitis, Infectious	10	12	3
Influenza	27	34	40
Measles	34	33	58
Measles, German	6	9	10
Meningitis, Aseptic	2	—	<1
Meningitis, Meningococcal	1	—	<1
Mumps	529	534	73
Pneumonia, Infectious	—	—	19
Rheumatic Fever	—	—	<1
Salmonellosis	34	14	16
Scarlet Fever	4	17	4
Streptococcic Sore Throat	161	237	8
Syphilis, Primary & Secondary	2	2	1
Syphilis, Early Latent	2	1	1
Syphilis, Late & Late Latent	13	14	6
Tetanus	—	—	<1
Weil's Disease (Leptospirosis)	—	—	<1

COMMENTS

We are at the peak of a mumps epidemic, and chickenpox is increasing.

As of 21 April, reports of influenza are rising rapidly. School absenteeism in the listening posts is up from a normal of 5.5% to 9.2% with a high of 12.7% in one high school.

The rise in gonorrhea of 24, 39, 39, 72 in four months is due to improved reporting by military services. Civilian cases have not increased.

W. F. LYONS

Medical Training . . .

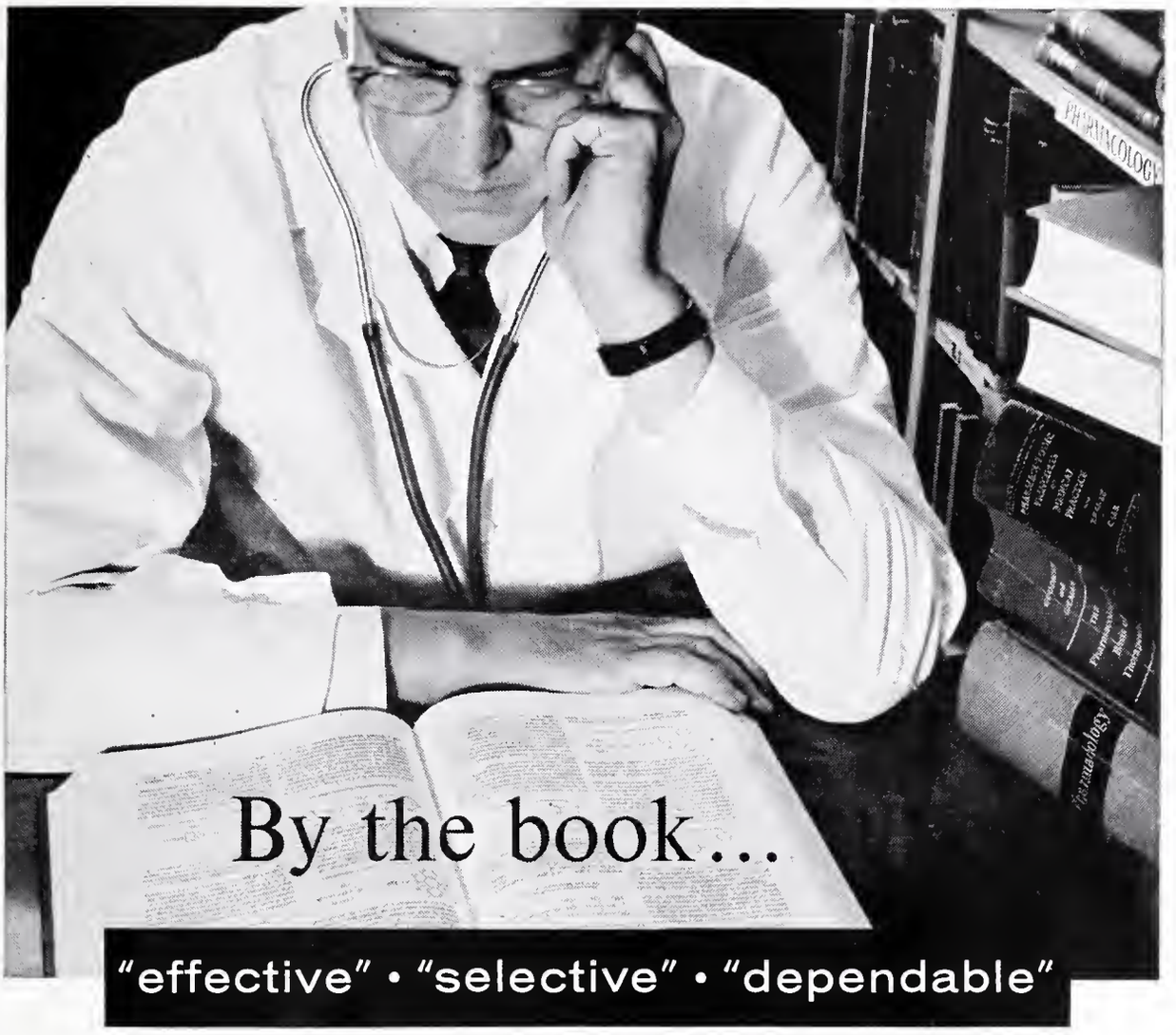
A course in laryngology and broncho-esophagology will be given November 9-21, University of Illinois, Chicago. Interested physicians write to Department of Otolaryngology, U. of I., College of Medicine, 1853 West Polk St., Chicago. The annual Otolaryngologic Assembly will take place on the same grounds October 3-9—a one-week condensed course for practicing otolaryngologists.

Visiting doctors **Oscar Auerbach** and **James Raleigh** presented some new approaches on the effects of smoking in the development of various diseases. Lectures were given at Queen's, St. Francis, Tripler, Kuakini and Children's, as well as on the neighbor islands.

A conference on alcoholism, held in Honolulu and on Kauai, brought **Dr. Aloysius Church,** a Detroit psychiatrist; **Dr. Richard C. Bates** of Lansing, Michigan, and **Dr. Edward J. Delahanty,** a psychiatrist from the University of Colorado School of Medicine. The purpose was to promote a better understanding of the syndrome by the public.

Eleven Japanese doctors, who specialize in cancer research, spent a week here participating in the Planning Meeting on Chemotherapy Screening, held under the auspices of the Panel on Medical Sciences, U.S.-Japan Cooperative Science Program. **Dr. Kenneth Endicott,** director of the National Cancer Institute, was part of the

continued page 406



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Many studies by many investigators over many years have established Pro-Banthīne (propantheline bromide) as the standard anticholinergic in the management of peptic ulcer and other gastrointestinal disorders.

It Is Effective—Hundreds of comparative laboratory and clinical trials and innumerable gratified patients have made Pro-Banthīne (propantheline bromide) the most widely-prescribed medication in its class.

It Is Selective—Its major effect is on the gastrointestinal and urogenital tracts. Secondary activity when noticeable seldom passes the point of temporary annoyance.

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These qualities have won such wide recognition in standard texts on pharmacology and therapeutics that to prescribe Pro-Banthīne (propantheline bromide) is truly to prescribe "by the book."

The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime.

Side Effects And Cautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthīne (propantheline bromide). It is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS 60680
Research in the Service of Medicine

An open letter on a new concept in cigarette filtration from the makers of new LARK cigarettes

DEAR DOCTOR: In the recent report of the Surgeon General's Advisory Committee on Smoking and Health, attention was drawn to the inhibitory effect of cigarette smoke on respiratory cilia. On page 34, the Report states: "Components of the gas phase of cigarette smoke have been shown to produce various undesirable effects on test animals or organs. One of these effects is suppression of ciliary transport activity, an important cleaning function in the trachea and bronchi (Chapter 6, p. 61 and Chapter 10, pp. 267-270)."

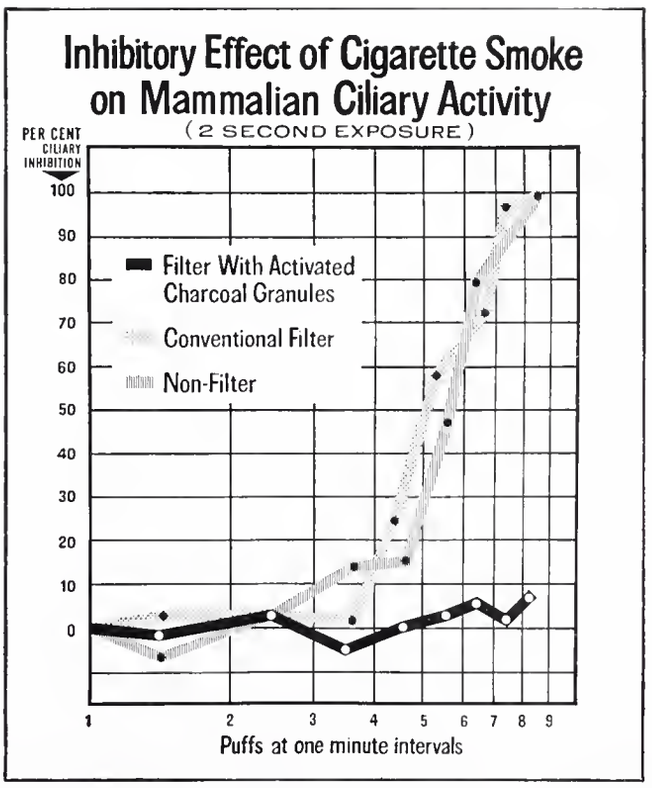
The Report also notes that there is a cigarette filter containing special charcoal granules which reduces certain gases which inhibit the activity of mammalian respiratory cilia. On page 61 of the Report it states: "Activated carbons differ markedly in their adsorption characteristics. Carbon filters previously employed in cigarettes do not have the specific power to scrub the gas phase. It has been reported that a filter containing special carbon granules removes gaseous constituents which depress ciliary activity (28)." The reference cited is "New England Journal of Medicine" (Kensler, C. J. and Battista, S. P., *269:* 1161-1166, November 28, 1963).

In 1954, Liggett & Myers Tobacco Company began a broadly based program of biological research on tobacco smoke which has been conducted in the Life Sciences Division of Arthur D. Little, Inc., Cambridge, Mass. In recent years, this research has centered on the gas phase of cigarette smoke, and the development of a specially treated charcoal-granule filter. This filter materially reduces the gases in cigarette smoke which contribute to the inhibition of the activity of mammalian

respiratory cilia in *in vitro* experiments. (see chart.)

Dr. Kensler points out in his paper referred to above: "Although it is recognized that these *in vitro* findings may not be directly extrapolated to the effects of cigarette smoke on human pulmonary tissue the use of the charcoal-granule filter will obviously reduce the level of exposure of the non-ciliated as well as ciliated bronchial and alveolar cells to potentially harmful smoke components."

The specially treated charcoal-granule filter discussed in the Kensler and Battista paper was the prototype of the one which is now available to the public on Lark cigarettes. Since some of your patients may have heard of this filter through the lay press, and may inquire about its basis in science, we believe you may wish to have the information at hand.



(Data from figure 6, page 1165, "New England Journal of Medicine," November 28, 1963)

Chart shows inhibition of the mammalian ciliary activity by the irritating gases in cigarette smoke:

1. The screened lines represent conventional filter and non-filter cigarettes and show how they produced 50% ciliary inhibition after 5 to 6 puffs and 100% inhibition after 7 to 8 puffs.

2. On the other hand, the filter with activated charcoal granules, represented by the solid black line, produced no significant inhibition (less than 10%) when the whole cigarette (8 puffs) was smoked.

LIGGETT & MYERS TOBACCO CO.



HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: JAMES YANO, Kaiser Foundation Hospital

Pelger-Huët Anomaly in Hawaii

The peculiar and rare Pelger-Huët anomaly, involving polymorphonuclear leukocytes, has not previously been reported in Hawaii. Since this anomaly resembles very closely a typical "shift to the left" the accurate and proper identification of the Pelger-Huët cells may prove to be rewarding in cases where a wrong interpretation could lead to extensive and unnecessary follow-up studies. Herewith is presented a case report and a family study of the Pelger-Huët anomaly recently found in Hawaii.

This nuclear anomaly of the polymorphonuclear leukocytes was first described by Pelger[1] in 1928. He reported this nuclear "shift to the left" of the neutrophils, with an unusual decrease in the number of nuclear lobes, in two patients with tuberculosis. Since both patients died shortly after the findings, he ascribed the anomaly to the tuberculous process and regarded it as a bad prognostic sign.

In 1931, Huët[2] found this same anomaly in three families. One of his cases occurred in the niece of one of Pelger's original two patients. Although the niece was suspected of having tuberculosis, Huët showed that the anomaly could also occur in healthy individuals and that no pathologic conditions could be attributed to it.

MENDELIAN DOMINANT

Huët also discovered that the familial trait was a dominant Mendelian character which could be inherited by both sexes. European literature associated the names of Pelger and Huët, as suggested by Schilling, with this peculiar deviation from the normal neutrophils.

The Pelger-Huët anomaly of leukocytes is characterized by an increase of non-segmented cells without any conformity to infective conditions or clinical states. These cells are predominantly with bi-lobed or "pince-nez" nucleus, i.e., a nucleus exhibiting a distinct bridge between two lobes with the chromatin network markedly condensed, while the cytoplasm, size and granular pattern are similar to those found in normal neutrophils. In most cases, the nuclear lobes do not increase more than two at the most. Frequently accompanying the "pince-nez" nuclear cells are immature-appearing neutrophils which resemble myelocytes or metamyelocytes except that the chromatin appears dense and mature, and the nuclear size is relatively small. Even the eosinophils and basophils appear with bi-lobed nuclei or with a single nucleus resembling immature cells.

CASE REPORT AND FAMILY STUDY

The patient presented here is a 27-year old woman of English-Irish-German descent, in apparent good health. During a routine examination of a Wright's stained blood smear, 69% of the polymorphonuclear leukocytes (including six eosinophils) contained either a single nucleus resembling a stab form or a bi-lobed nucleus of the "pince-nez" type previously described. Other laboratory studies revealed the following data: hemo-



Pelger-Huët cell. Right: "stab" form with mature chromatin network (X1000).



Pelger-Huët cells with typical pince-nez nuclei (X1000).

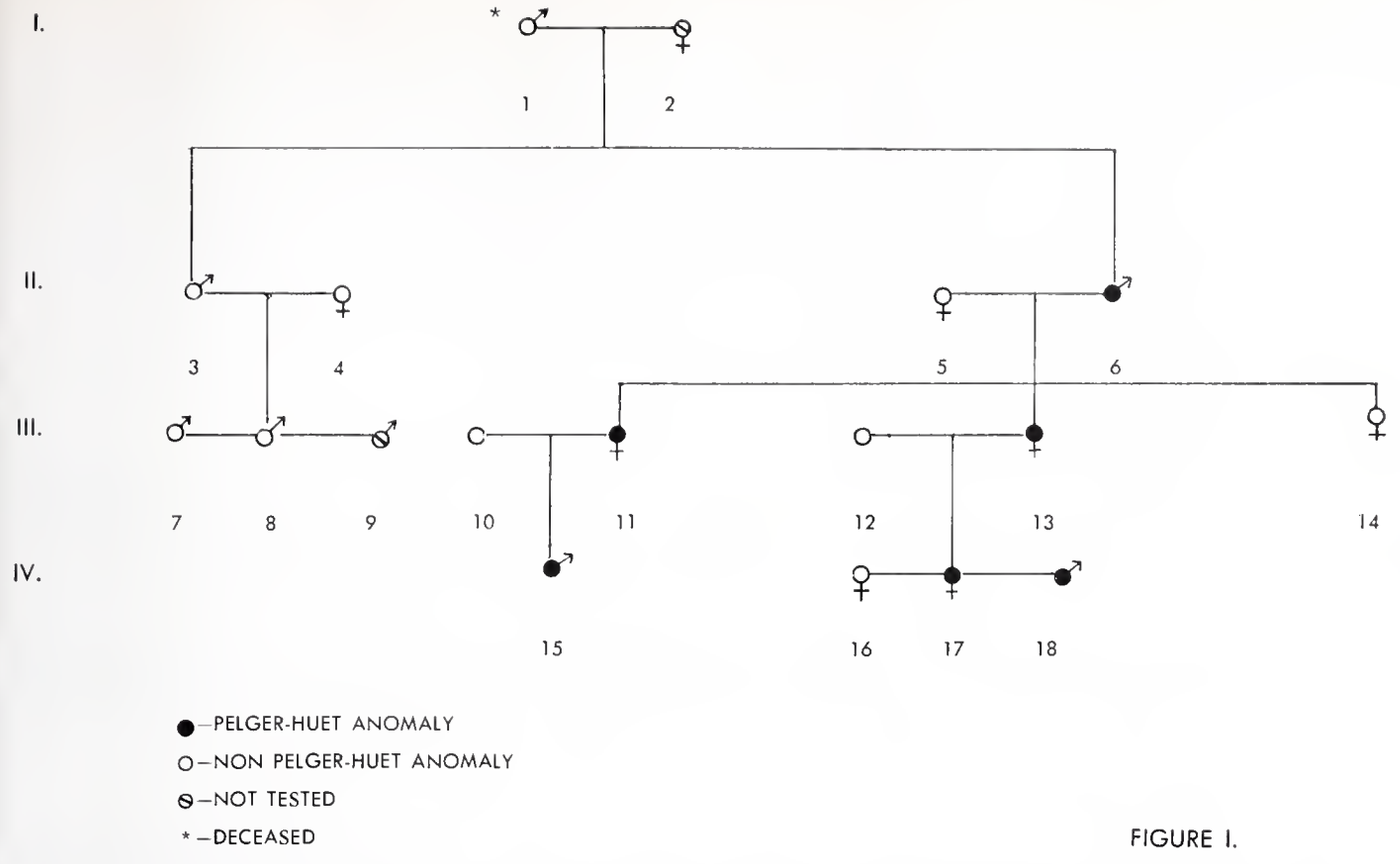


FIGURE I.

globin—15.3 gm%; hematocrit, 46%; WBC—14,350/cu mm with 34% bi-lobed, 29% "stabs" with mature-appearing chromatin network in the nuclei, 26% lymphocytes, 5% monocytes, and 6% eosinophils, also bi-lobed. Since no report has yet described any hemoglobinopathies or glucose-6-phosphate dehydrogenase deficiency in patients with known Pelger-Huët anomaly, such tests were included in this study of the patient and on all of her family members who were available for testing. Adult hemoglobin contents were determined by paper electrophoresis, using Veronal buffer at pH 8.6; fetal hemoglobin determinations were made by the alkali denaturation method; and glucose-6-phosphate dehydrogenase (G-6-PD) activities were performed by the qualitative test tube technique of Motulsky and Campbell.[3]

Since the anomaly is known to be familial, other members of the family were studied in similar manner, as illustrated in Fig. 1. The patient's son and daughter were positive, while another daughter was negative; also her father, a sister, and a a nephew were also found positive. The data of all laboratory tests performed on the patient and her family members are presented in Fig. 2.

DISCUSSION

According to Davidson,[4] these Pelger-Huët cells seem to possess normal phagocytic power for bacteria, and did not show any evidence of a relationship between any blood groups and the determination of the anomaly. Although the sex chromatin was evident in buccal smear preparations, Skendel and Hoffman[5] were unable to find the "drumstick" or sex chromatin in the neutrophils of females with this anomaly. These cells also possess normal alkaline phosphatase activity[6] as well as normal survival time.[7] According to van de Saar,[8] no specific deviations from the normal hemoglobin, red cells, blood platelets, or sedimentation rate could be observed in these patients.

The mechanism responsible for the development of this anomaly is not yet known. Stahel,[9] who was one of the first to examine the bone marrow of a patient with Pelger-Huët anomaly, believed that, although the stem cells of the marrow are normal, there is a retardation of development in the myelocyte stage. Progressive condensation of the chromatin in the nucleus results, with passage through a recognizable metamyelocyte or band form stage due to the hereditary anomaly.

It is generally accepted that this hereditary anomaly is harmless. However, the appearance of a pseudo–Pelger-Huët anomaly associated with certain pathologic conditions has been observed in enteritis,[10] Fanconi's panmyelopathy,[11] virus influenza,[12] malaria,[13] and mongoloidism.[14] A careful morphologic examination of a well-stained blood smear, in addition to tracing of the familial inheritance of the trait, will help differentiate these diseases from the harmless hereditary Pelger-Huët anomaly. Acquired pseudo-Pelger anomaly has been associated with chronic myelogenous leukemia,[15] lymphatic leukemia,[16] polycythemia[14] and recently with severe myxedema[17] and megalo-

NAME	AGE	P-H ANOMALY	HG8.	HCT.	WBC.	DIFFERENTIAL										G-6-PD	HG8. ELEC.	FETAL HGB.
						NEUTROPHILS — NO. OF LOBES						LYMPH	MONO	EOS	BASO			
						0	1	2	3	4	5							
A. E. II 6	57	♂	15.5	46.5	9,050	3	17	35	—	—	—	24	13	1	—	N	N	N
M. E. II 5	59	♀	12.5	38	8,950	—	1	32	32	27	—	22	3	4	—	N	N	N
P. B. III 13	27	♀	15.3	46	14,350	—	29	34	—	—	—	26	5	6	—	N	N	N
R. B. III 12	25	♂	14.9	45	7,750	—	6	24	32	5	—	25	3	5	—	N	N	N
J. B. IV 16	7	♀	12.1	39	10,840	—	4	22	32	5	—	27	6	5	—	N	N	N
B. B. IV 17	5	♀	12.3	39	10,500	—	30	52	—	—	—	10	7	1	—	N	N	N
R. B. Jr. IV 18	4	♂	11.6	37	7,850	—	27	39	—	—	—	28	2	4	—	N	N	N
A. H. III 11	23	♀	12.9	38.5	4,910	—	29	27	—	—	—	37	5	2	—	N	N	N
R. H. I III 10	26	♂	14.9	47	8,050	—	4	30	52	13	—	15	2	1	—	N	N	N
R. H. II IV 15	3	♂	12.5	37	11,290	1	11	27	—	—	—	40	6	15	—	N	N	N
B. E. III 14	21	♀	14.0	43.5	7,800	—	3	16	43	20	1	16	—	1	—	N	N	N
A. E. II 3	53	♂	14.0	44	5,500	—	3	20	27	7	—	32	11	—	—	N	N	N
A. E. II 4	50	♀	14.4	44	6,250	—	7	21	27	9	—	20	4	10	2	N	N	N
A. E. III 7	19	♂	14.0	42	3,500	—	2	20	31	5	—	35	5	2	—	N	N	N
B. E. III 8	18	♂	15.7	48	7,700	—	2	21	30	10	—	29	7	3	—	N	N	N
B. E. III 9	13	♂	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

FIGURE 2.

blastic anemia.[18] Door and Moloney[14] established that in myeloid metaplasia the pseudo-Pelger cells showed a strongly positive test for alkaline phosphatase stain, peroxidase reaction, and cytoplasmic esterase activity.

SUMMARY

Discovery and investigation of a patient of English-Irish-German ancestry in Honolulu, Hawaii, and of her family members with a hereditary nuclear defect of the Pelger-Huët anomaly is reported. In the family study, five additional cases were discovered. The patient and 14 additional family members showed normal results for hemoglobin electrophoresis, fetal hemoglobin, and glucose-6-phosphate dehydrogenase activity.

ACKNOWLEDGMENT

Special acknowledgment and appreciation is expressed to Robert Jim, M.D., internist and hematologist in Honolulu, Hawaii, for his assistance, interest and criticism of the study and manuscript. Also to James G. Bennett, M.D., Pathologist at Kaiser Foundation Hospital, Honolulu, Hawaii for guidance. ■

JAMES R. YANO, B.S., MT(ASCP)
Chief Medical Technologist
Kaiser Foundation Hospital

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PURPOSE	To measure how adequately Blue Shield Plans cover medical expenses.
UNIT OF MEASUREMENT	Comparison of Blue Shield (HMSA) payment to the doctor's charge for selected claims during survey period.
WHY?	To develop national, uniformly measured, Plan performance data so comparison with other Plans under similar circumstances can be undertaken.
WHEN?	First questionnaires should go out about the end of May.
WHERE?	All 83 Blue Shield Plans, which means the entire U. S.
METHOD OF SELECTION	A statistical sample of claims coming into the HMSA during the survey period will be selected at random.
WHO?	There is no way to predict beforehand who will be selected or how many times they will be selected.
TIME	The questionnaire was designed to take only about one minute to fill out.
RELIABILITY	Because the Plan's profile will be determined by the selected claims, it is vital that a high percentage be returned accurately.
CONFIDENTIAL	No doctor nor patient will be the subject of the analysis and no individual will be identified in any way.
KOKUA	It would be helpful if doctors could return the questionnaires as soon as possible, but more important is that all questionnaires be returned when time allows.

Member of Western Conference of Prepaid Medical Service Plans

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HAWAII MEDICAL SERVICE ASSOCIATION

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County Society News *continued from 386*

the complaint to write the Society and a meeting would be arranged.

The meeting concluded with a talk by Dr. Oscar Auerbach on the Effect of Smoking on Various Respiratory Conditions."

Maui

Guests present at the February 5 meeting included Drs. Virginia Apgar, Donald Char, K. Y. Lum, Bienvenido Garcia, Betram Weeks, Mr. John Pompelli, and Mesdames Carolyn Patterson, Haling, Cole, Sanders, and Fleming.

After Dr. Apgar's talk, Mrs. Patterson and Dr. Char discussed the Foundation's Children's Center of Research in Honolulu.

Dr. K. Y. Lum discussed the Mental Health Planning Program. Mr. Pompelli spoke of the role of the AMA.

The chair ruled that there was no quorum and so no official action was taken at the short business meeting which followed the scientific program. ■

Hawaii Medical Association *continued from 387*

The Council was advised that Senator Vincent Yano expressed considerable displeasure and is somewhat disturbed by the underground movement on the part of some members of the Association to sabotage bills without first appearing to express opinions at public hearings. It was suggested that these committee hearings be widely publicized. Senator Yano felt that some of the doctors should be present at the hearings.

ACTION:

Dr. Allison agreed to be present at the Public Hearing to be held on Friday, March 6, 1964.

It was noted that Dr. Richardson would not appear at the hearing on behalf of the HCMS but he had already spoken to Senator Yano.

ACTION:

It was voted to approve the remainder of the Legislative Committee's report, and to commend them for the excellent job they are doing.

Medical Care Plans & Fees: The fee survey progress was noted.

Mental Health: The Mental Health Committee report was circulated and reviewed.

ACTION:

It was voted to approve the request of the chairman of the Mental Health Committee to make application for funds from NIMH to be for courses to specialist groups for a period of one to five years and that these funds be channeled through the Hawaii Medical Association.

Public Relations: The newly recruited group of doctors which has been meeting every Tuesday morning for breakfast to exchange information which will enable them to become medical spokesmen was commended. Rumors of changes in the King-Anderson Bill to shorten the hospitalization period and limit coverage were noted. It was suggested that the Public Relations Committee step up their program because of these new changes.

UNFINISHED BUSINESS

Rental Fees: Letter from Mrs. I. Storme, Director of

continued page 402

OPPORTUNITY

Westgate Center is announcing its 39,000 square feet of floor space located on Pupupani Street in Waipahu just west of Waipahu High School.

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Reports & Snorts

Schering's Tremin, trihexylphenidyl hydrochloride, recently introduced for drug-induced Parkinsonism, is said to relax rigidity, relieve depression, and minimize tremor in that disease.

• • •

Winthrop's "Win-20,740" was recently reported from Minneapolis General Hospital (*Minnesota Med.* 46:1230, 1963) to be an effective and safe obstetrical analgesic, apparently non-addicting.

• • •

Analab Instrument Company offers a Dual-Trace Sampling Oscilloscope with a tunnel diode trigger circuit that can display signals with repetition rates to over 5GC (can you believe it?) without external pre-trigger signals, count-down generators, or delay lines. They have sweep ranges from two microseconds/cm to ten picoseconds/cm. Direct measurement of pulse jitter with resolution up to one picosecond is possible. And all for only $2,905!

• • •

Saunders announces, on page 343 of this issue, three new books: Avery on *The Lung and Its Disorders in Newborn Infants,* Cecil and Conn's third edition of *The Specialties in General Practice,* and Stoddard's *Case Studies in Obstetrics and Gynecology.* Write for one or two, or all three, and please mention the JOURNAL if you do. Saunders is a faithful advertiser!

• • •

Uncle Sam spent $1¼ billion in fiscal '62-'63 on medical care for people on public assistance rolls. This represents 20 per cent of all government expenditures for personal health care, and 25% of all government expenditures for public assistance programs, according to the Health Information Foundation of the University of Chicago.

• • •

Organon's Pregnosticon, an immunodiagnostic urinary pregnancy test, takes 3 minutes to set up and 2 hours to give a reading. A brown ring in the test-tube means pregnancy, a diffuse sediment no pregnancy. The test is available in a 20-test kit with a mirrored reading rack. West Orange, New Jersey is the address.

• • •

You'll have to find out for yourself whether it works or not, but Index is the name of a new disposable do-it-yourself enema sold over the counter by Johnson and Johnson for 49 cents, and it only contains about a teaspoonful of liquid!

Of the 60,202 doctors who replied to *Modern Medicine's* questionnaire on smoking, 95 per cent thought smoking dangerous to health, and only 22.5 per cent were smokers. One-third had stopped smoking, one-sixth had either cut down or changed smoking habits in some way. One-third of psychiatrists, and two-thirds of pediatricians and thoracic surgeons, were advising patients not to smoke. *Modern Medicine's* unmodern roster of states (charts 2c, 3c, and 6b) placed D.C. after Delaware, but Alaska after Wyoming and Hawaii nowhere. Bad cess to you, *M.M.!* And you with a Hawaiian editor, too!

• • •

1-ethyl-7-methyl-1,8-naphthyridin-4-one-3-carboxylic acid, or nalidixic acid, is marketed by Winthrop as NegGram, which means that it n(alid)ixes Gram negative organisms, notably Neisseria (both gonorrheae and meningitidis), Pasteurella pestis, Aerobacter aerogenes, Brucella (abortus and melitensis), E. coli, Hemophilus (influenzae and pertussis), Pseudomonas, and a lot of Salmonellas.

• • •

Pfizer virologists have made a successful experimental approach to a radically new technique for protecting animals against virnses: stimulating body production of interferon. The last time we read about this, it was being used to save the lives of some characters in the Flash Gordon comic strip, about 1959. It is still some distance from the corner pharmacy—but it's coming!

• • •

The main hallucinogens (which usually don't produce hallucinations, since the user rarely mistakes his altered sensory experiences for reality!) are mescaline, from peyotc cactus; LSD or d-lysergic acid diethylamide, from ergot; and psilocybin and psilocin, from mushrooms such as Psilocybe mexicana and Stropharia cubensis.

• • •

The Moho is the nickname of the Mohorovicic discontinuity, which separates the earth's crust from its mantle; the Mohole is the hole through it that was suggested in 1957 and is still being planned by the National Science Foundation, with the advice of AMSOC (the American Miscellaneous Society), whose slogan for the project is "The ocean's bottom is at least as important as the moon's behind!" ■

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the Mabel Smyth Building, was received informing the HMA that the new rate for adjustment in maintenance fees for the HMA executive offices will be between 41¢ and 45¢ a square foot. This includes air conditioning. The total rent, effective March 1, will be $264.00.

Voluntary Health Agencies: As requested, the AMA was solicited for evaluation of voluntary health agencies. A copy of the AMA handbook was sent to the HMA executive offices. The handbook lists the purpose, organizational structure, financial data, program, and key personnel. Dr. Allison thought the Oahu Health Council has a committee that does study these organizations and has on occasion disapproved some solicitation by voluntary health organizations.

ACTION:

It was voted to have the HMA staff investigate to find out what is going on in this community about solicitation by voluntary health agencies and report back to the Council.

Cigarette Advertising: A request for acceptance of cigarette advertising in the HAWAII MEDICAL JOURNAL was referred to the Council. It was noted that the mail ballot resulted in a vote of 8-3 in favor of accepting the advertising.

HAMPAC: Dr. West announced the results of the HAMPAC election: Dr. Liljestrand, Chairman; Dr. Chalmers, Vice-Chairman; and Dr. George Goto, Secretary-Treasurer.

Interim Meetings: Dr. Allison wanted to hear discussion about the possibility of holding Council and scientific meetings on the neighbor islands. It was noted that there would be little work on the part of physicians on the neighbor islands because most of the planning and

continued page 404

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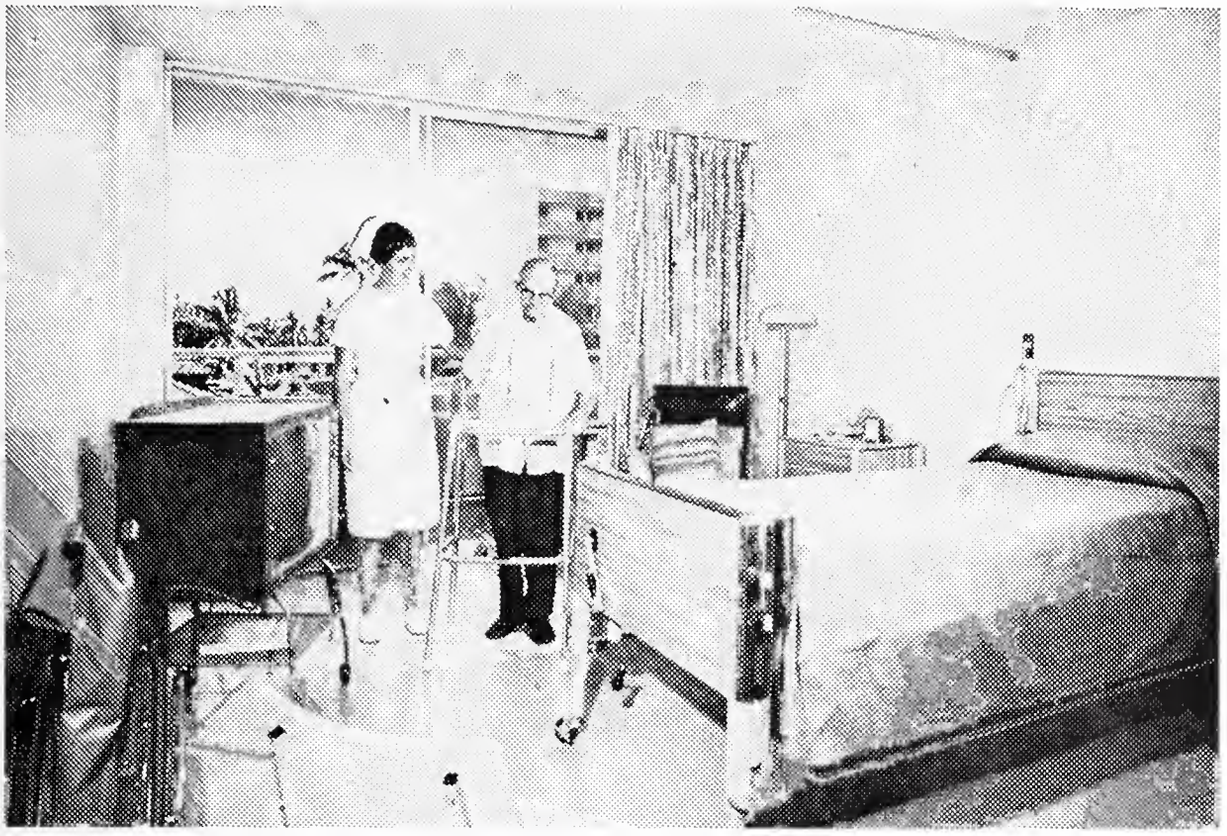


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Hawaii Medical Association continued from 402

arranging would be done in Honolulu. It was felt that these meetnigs would be held once a year on one of the neighbor islands and that it would attract men from all over. Dr. West said if a meeting were held, it would start on Friday and end Sunday. It would probably be held on Maui first. It was suggested that the President talk to the physicians on Maui since he will be going there March 20. There was much discussion as to whether or not many doctors from Oahu would be interested in attending a meeting on one of the neighbor islands and exactly how many would turn out.

ACTION:

It was voted to take a poll of the membership to see how many would be interested in attending a meeting if it were held on the neighbor islands.

NEW BUSINESS

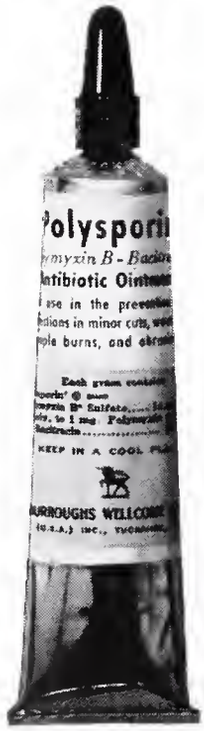
Committee Appointments: It was noted that the President-elect is studying returns and working on his appointments. Dr. Allison stated that he would like to have neighbor island members on committees to serve actively by reading the minutes and by writing letters giving their suggestions, criticism, etc. It was noted that Dr. West set up a policy to send minutes of all meetings to each county president once a month.

Dr. Allison felt that a lot of work could be done by word of mouth to see how many young doctors in the medical profession would be interested in participating on committees. He said it would be impossible to have everyone on every committee.

Editorial Policy: Dr. Allison stated that the Council is the editorial board of the HAWAII MEDICAL JOURNAL. However, he stated that he was approached by two dif-

continued page 406

in treating topical infections, no need to sensitize the patient



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Hawaii Medical Association *continued from 404*

ferent parties, one stating that the editorials in the HAWAII MEDICAL JOURNAL were too strong and the other stating that they were too weak. It was noted that Dr. Arnold, Jr., should be able to approach a Board other than the Council for advice or consultation. It was stated that this has been requested many times by the editor. Dr. Giles stated that this was not requested when he was President. There was considerable discussion about what the editorial policy should be. It was felt that the Editor should be given leeway in expressing his thoughts and that a board, if appointed, should not be in a position to dictate what to say. There was discussion about whether or not the JOURNAL Editor is expressing his personal opinion or that of the membership; whether he has the same obligation to the Society as does the President.

ACTION:

It was voted to form a Publications Committee to oversee the publication and finances of the HAWAII MEDICAL JOURNAL and to rule on editorial, publishing, and advertising policies.

President's Page: There was considerable discussion about the President expressing his personal opinions on the President's Page in the HAWAII MEDICAL JOURNAL; whether the President's opinions should be in conflict with the basic views of the Society. The question arose whether the content of the President's Page should be made known to the membership or some advisory group before going to press. Dr. West stated that in the last JOURNAL, he stated that his opinion was of the minority. The probability of lay people's feeling that the President's expression reflects those of the Association as a whole was discussed. Opinions on whether the President's Page should be more restricted than the editorials were voiced.

ACTION:

It was moved and seconded that the policy of the Council be such that the President of the HMA be allowed to use the President's Page of the HAWAII MEDICAL JOURNAL as he wishes for the best interests of the HMA. The motion was lost.

It was voted to get an up-to-date poll of the membership on the Medical Practice Act.

VD Committee: Dr. Allison stated that it has been suggested that there would be no need for a VD Committee. He said if there were no objections then there will be no appointments made for a VD Committee and that this committee would be combined with the Communicable Disease Committee.

Disaster Committee: There was much discussion about whether or not the Disaster Committee should be on a county or State level. It was felt that if it is a local disaster then it should be part of the county; however, if it is a national disaster, then it would be on the State level. It was suggested to have a liaison committee to be made up of the chairman of the Disaster Committee from each county. Dr. Allison suggested to refer this to the County Medical Society to see how they feel about this. ■

RANDAL A. NISHIJIMA, M.D.
Secretary

Notes and News *continued from 390*

11-man U.S. delegation, exchanging information with the Japanese group.

University of Hawaii Associated Students sponsored a four-day Stop-Smoking program, which was a total flop. No students turned out for the planned noon sessions, which had to be cancelled. Too many midterm exams? Or just not interested in health at that age?

"Community Planning for Child Health Fragmented or Integrated" was discussed by **Dr. Amos Christie,**

Professor of Pediatrics at Vanderbilt University, recent visiting professor at Children's Hospital.

Another famous man who lectured to a full house in Children's Hospital Penthouse was **Dr. Guido Fanconi,** of Fanconi syndrome fame. The last of three sessions included case presentations of vitamin-D-resistant rickets and of galactosemia. The eminent Zurich pediatrician claims the latter deficiency takes less than 20 minutes to diagnose.

A nine-week work-study course in mental health and mental retardation will be given at University of Hawaii to undergraduates during the summer session. **Dr. George Schnack** is project director.

Local Contributions to Medical Literature . . .

"Prosthesis and Autogenous Dermal Grafts," by **Drs. Paul Gebauer, Carl Mason** and **Albert K. S. Chun,** in the February, 1964, *Journal of Thoracic and Cardiovascular Surgery.*

"Observations on the Outbreak of Infection with a Newly Recognized Enterovirus (JV-4)," by **Drs. Leon Rosen** and **Jerome Kern** in the *American Journal of Hygiene,* January, 1964. Same men in the same issue also wrote on Enteroviruses JV-5, JV-6 and JV-10.

Government ℞ . . .

President of U.H. Thomas Hamilton went on record opposing a four-year medical school for Hawaii. He wants the University to begin with the first two years of medical education, but the cost of the final two clinical years is "very, very great indeed."

Dr. Carolina D. Wong, a part-time physician at U.H. for the past 10 years, has charged that the Student Health Service is poorly organized and that the Director is requesting unnecessary funds. "Not so," replied Director **Dr. Earl D. Lovett,** who claims that requests for staff and equipment are based on recommendations and standards established by the American College Health Association. During the recent past, when funds for nurses to staff the service ran out, an ambulatory patient had to answer the phone at the newly-built Ossipoff-designed infirmary.

Miscellany . . .

Kauai has its money problems, and the Board of Supervisors made no small matter of it, when they found out that Harold Newsome, Veterans Memorial Hospital superintendent, hired an alien (a Canadian wahine x-ray lab tech) to replace the former incumbent, who quit last September. Other problems on the Garden Isle include medical and hospital care of County pensioners at the Veterans Hospital, promised them but apparently not forthcoming because funds had not been set aside.

The Health Facilities Planning Council of Hawaii, under its Executive Director, **Dr. Edward Colby,** has announced that half of Oahu's pediatric beds were empty in 1963, or enough to provide for a 34 per cent population expansion—projected for not sooner than 1970.

Wilcox Hospital plans to build an 18,000 square foot $500,000 out-patient clinic on the grounds just north of the hospital. Work is to begin in a few weeks and completion is scheduled for early 1965.

More than $100,000 is being spent in cancer research in Hawaii this fiscal year by the American Cancer Society, far more than any other voluntary health agency is spending, regardless of the amount raised, says **Dr. Irvin L. Tilden,** Hawaii's representative to the national board of A.C.S.

The Hawaii Heart Association is going to spend up to $50,000 this year to support research projects in cardio-

continued page 412

reduce or obviate the need for transfusions and their attendant dangers

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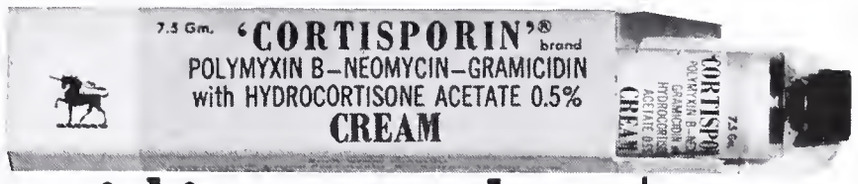
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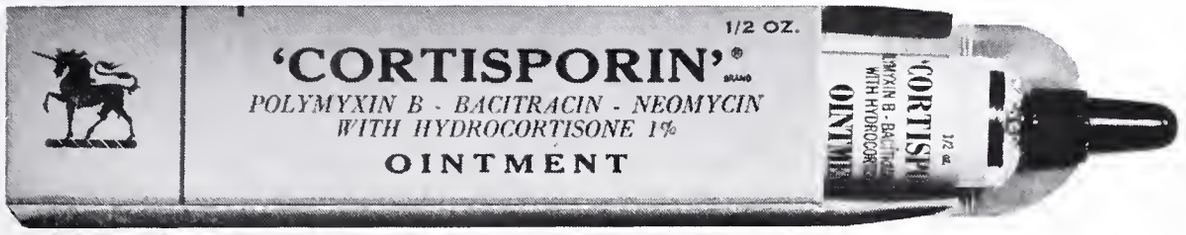
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Available: In tubes of 7.5 Grams.

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In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindieations: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

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References:

1. Phelps, J. A.; Hiller, A. J., and McHargue, A. M.: Disposable Nurser System for Infant Feeding: Comparison with Usual Glass Nurser Method. Part I—A Clinical Study, Hosp Management 93:30-33 (Jan.) 1964

2. Brewer, G. M.: New Nurser System for Infant Feeding. Part 2—Industrial Engineering Study Comparison with Glass Nurser, Hosp. Management 93:42-44 (Feb.) 1962.

3. Goldman, J.; Littauer, D., and Wessen, A.: A Sterile Disposable Nurser System for Newborn Babies and Older Infants, St. Louis, a manograph published by the Washington University Press, 1962.

4. Ring, I. R.; Vignec, A. J., and Donovan, D. J.: A Sterile Disposable Nurser System for Infant Feeding: A Bacteriological Study, Hosp. Progress 43:78-82 (Sept.) 1962.

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Notes and News *continued from 407*

vascular and related fields. Interested physicians and scientists should contact **Dr. George W. Henry** to file project applications.

About 12,000 islanders of Japanese descent will be asked to participate in an international health survey to be conducted by U. of H. in cooperation with the National Institutes of Health, in order to find possible causes of stomach and lung problems. **Dr. Richard K. C. Lee,** director of public health and medical activities at U.H., is project director. Some sample questions to be asked: "Do you drink very hot miso soup?" "Do you season salt-pickled radish with shoyu?" "Do you smoke cigarettes?" etc. No physical exams will be done.

The wives of **Drs. Don Jones** and **B. A. Richardson** spearheaded a drive as part of the Honolulu County Medical Society Woman's Auxiliary program to send plane-loads of milk and clothing to Laos, when they learned from a medical aid team there of a huge need for these items.

A roofless, termite-ridden building, about to be razed, has been completely repaired and rejuvenated into a shiny recreation hall by members of Kapa-Moi and Waialae Lions Clubs, and turned over to the Hawaii Association to Help Retarded Children. **Dr. John C. Milnor,** Association President, was pleased with the work of the 40 Lions, who labored for two months, wielding hammers, saws and paint brushes on Sundays, to bring new life to the building, previously considered to be beyond repair.

St. Francis Hospital will build a new $500,000 service wing within the next two years. It will house research lab, laundry, maintenance and storeroom facilities, according to Sister Maureen, Administrator.

Dr. Edward W. Boone was appointed assistant medical director of HMSA effective May 15. ■

Book Reviews *continued from 384*

logical evaluation, and treatment of pulmonary diseases. This is the first revision of a text which has become a standard reference book for all those interested in this field. The second edition very adequately reflects these changes in most areas.

The subject matter, presented in easily understandable form, can be read without undue effort and can be of great help to both the generalists and the specialists in thoracic diseases. For those who might wish to study a particular subject more completely, an excellent and up-to-date bibliography is presented at the end of each chapter. The illustrations, principally x-rays, are of excellent quality; in some sections line drawings are added for clarity.

Many chapters are outstanding, but for the sake of brevity, we will mention only three. The subject of cigarette smoking and bronchogenic carcinoma is presented at length from both sides of the question and the reader is allowed to draw his own conclusions.

Pulmonary function testing is dealt with in depth and probably to a degree which is impractical to the average clinician.

The final chapter deals with pulmonary diseases of occupational origin, bringing out the legal implications, of which we must all be aware these days.

This excellent revision assures this book of remaining the standard reference work in diseases of the chest for some time to come.

NIALL M. SCULLY, M.D.

Atlas of Plastic Surgery, 2nd Ed.

By Morton I. Berson, M.D., 336 pp., $23.00, Grune & Stratton, 1963.

THE SECOND EDITION of Berson's Atlas of Plastic Surgery has many shortcomings, and little to recommend it. On

continued page 414

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the plus side, it is beautifully bound; the print is very legible; there is an excellent arrangement between text material and illustrations, making the subject matter easy to follow; and the illustrations are well done. On the deficit side, the subject matter is limited, many of the photographs are of poor quality; inaccuracies are frequent, and many of the recommended procedures are open to criticism.

In the preface, the author states that the scope of the book is limited to cosmetic surgery with which he has had personal experience. The limited subject matter, therefore, is treated in a very subjective fashion. Many of the basic concepts of plastic surgery as a whole are completely missing.

In several instances, the preoperative and postoperative photographs are not comparable in position, lighting, area photographed, and attitude of the patient. In other cases, the views necessary to accurately judge the results of the procedure are missing.

The Atlas contains several inaccuracies. For example, it would be impossible to arrive at illustration "B" using incisions as outlined in illustration "A" on page 307. The Z-plasties illustrated on pages 22 and 23 would aggravate, rather than alleviate, the diagrammed conditions. Hypertrophic scars on page 16 are called keloids. The placing of incisions in Langer's lines, as recommended on page 3, is incorrect in many areas of the body. For example, incisions in the antecubital fossa should be placed at right angles to Langer's lines.

Many competently trained plastic surgeons would heartily disagree with a great many of the suggested procedures. These include the following: Some of the illustrations of wound closure; use of irradiation to treat hemangiomas; external fixation to treat zygomatic fractures; Sano technique for skin grafting; use of scar tissue as a split thickness skin graft; illustrated techniques for finger reconstruction, resurfacing of hand, and cutting of skin grafts; and the author's techniques for correction of syndactylism, gynecomastia, bilateral cleft lip, and cartilage transplant to the mandible.

For the trained plastic surgeon, the book offers nothing new. For the physician not trained in the basic principles of plastic surgery, it is not reliable enough to be recommended.

ELDON R. DYKES, M.D.

Pictorial Handbook of Fracture Treatment, 5th Ed.

By Edward L. Compere, M.D., F.A.C.S., Sam W. Banks, M.D., F.A.C.S., and Clinton L. Compere, M.D., F.A.C.S., 480 pp., $8.00, Year Book Medical Publishers, 1963.

AS THE AUTHORS state in the preface, this book is designed primarily for medical students and for physicians in the general practice of medicine. It lies in the zone between an elementary primer and an advanced text in fracture surgery. As indicated in the title, the pictorial or graphic illustrations compose a large section of the book, and are extremely well conceived and executed.

The book is divided into various subdivisions such as general considerations, including the diagnosis of fractures, immobilization, emergency treatment, complications, etc. The basic concepts are excellent, and there are chapters of the text which appear to be outstanding; namely, the section on immobilization of fractures, treatment of ankle fractures, plaster of paris technique, and the treatment of forearm fractures.

If any criticisms were to be offered it would seem that detailed operative procedures such as open reduction and fixation of femoral neck fractures, osteotomies, and so

continued page 416

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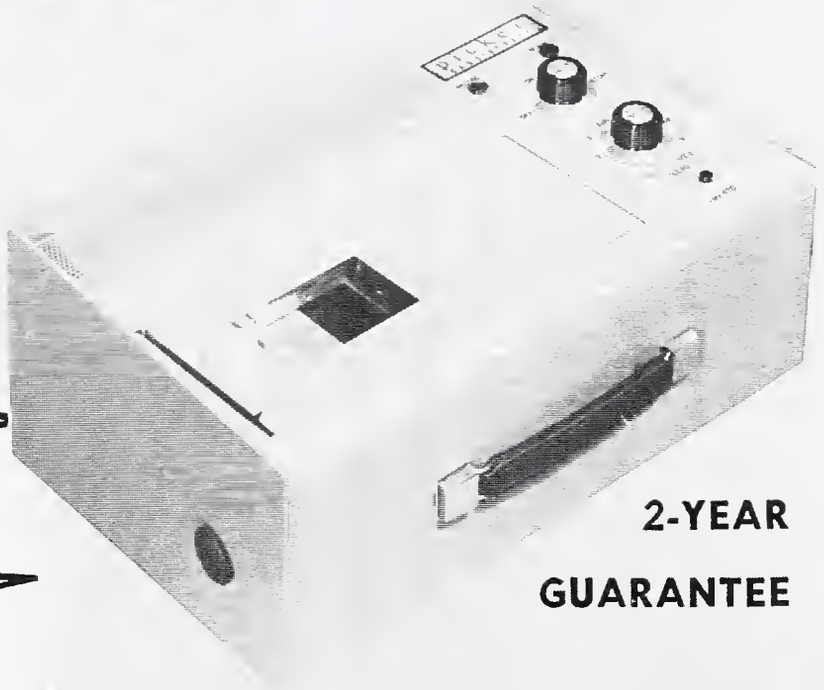
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forth, should be confined perhaps to a more advanced text, as it would be rare for a general practitioner of medicine to perform this type of surgery.

In the over-all picture, the book is well organized and should make an excellent addition to any physician's library.

RICHARD S. DODGE, M.D.

Medical Pharmacology, 2d Ed.

By Andres Goth, M.D., 585 pp., $11.75, The C. V. Mosby Company, 1964.

IF A PHYSICIAN is to expertly utilize today's morass of drugs, many of which are inefficacious and marketed rapidly with insufficient testing, he must first secure a comprehensive knowledge of clinical pharmacology. This text offers such knowledge.

Written mainly for students and practitioners, Dr. Goth's book emphasizes principles and current concepts of drug action rather than raw, factual information. His presentation is lucid, straight forward and easily understood and retained. The author has obviously written a book with those of us who must rely on self education in this field, in mind.

M. G. BOTTICELLI, M.D.

Also Received

Brain Mechanisms and Intelligence

By K. S. Lashley, 186 pp., $1.75, Dover Publications, Inc., 1963.

NEUROPHYSIOLOGY in relation to brain injury. Deep but well done.

CIBA Foundation Symposium on Lysosomes

Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.D., 446 pp., $11.50, Little, Brown & Co., 1963.

CELL CHEMISTRY through the ultramiscroscope. Fascinating, but well above the average physician's head!

Thrombophlebitis

By J. Earle Estes, B. S., M.S., M.D., 66 pp., $4.50, Charles C. Thomas, 1964.

A CLINICAL APPROACH to a clinical topic, by a Mayo Clinic "retiree."

1963-1964 Year Book of General Surgery

By Michael E. DeBakey, M.D., 592 pp., Year Book Medical Publishers, Inc., 1963-1964.

1963-1964 Year Book of Medicine

By Paul B. Beeson, M.D., 807 pp., $8.50, Year Book Publishers, Inc., 1963-1964.

1963-1964 Year Book of Obstetrics and Gynecology

By J. P. Greenhill, B.S., M.D., F.A.C.S., F.I.C.S., (honorary, F.A.C.O.G.), 584 pp., $8.50, Year Book Medical Publishers, Inc., 1963-1964.

WHAT can one, what need one say in a review of the year books? These are as handsome and nutritious as their predecessors; and surely, no less dispensable.

Self-study Guide of Mathematics Used in Nursing

By Geraldine G. Price, R.N., M.S., 65 pp., $2.50, G. P. Putnam's Sons, 1964.

A GREAT MANY doctors could study this profitably! ■

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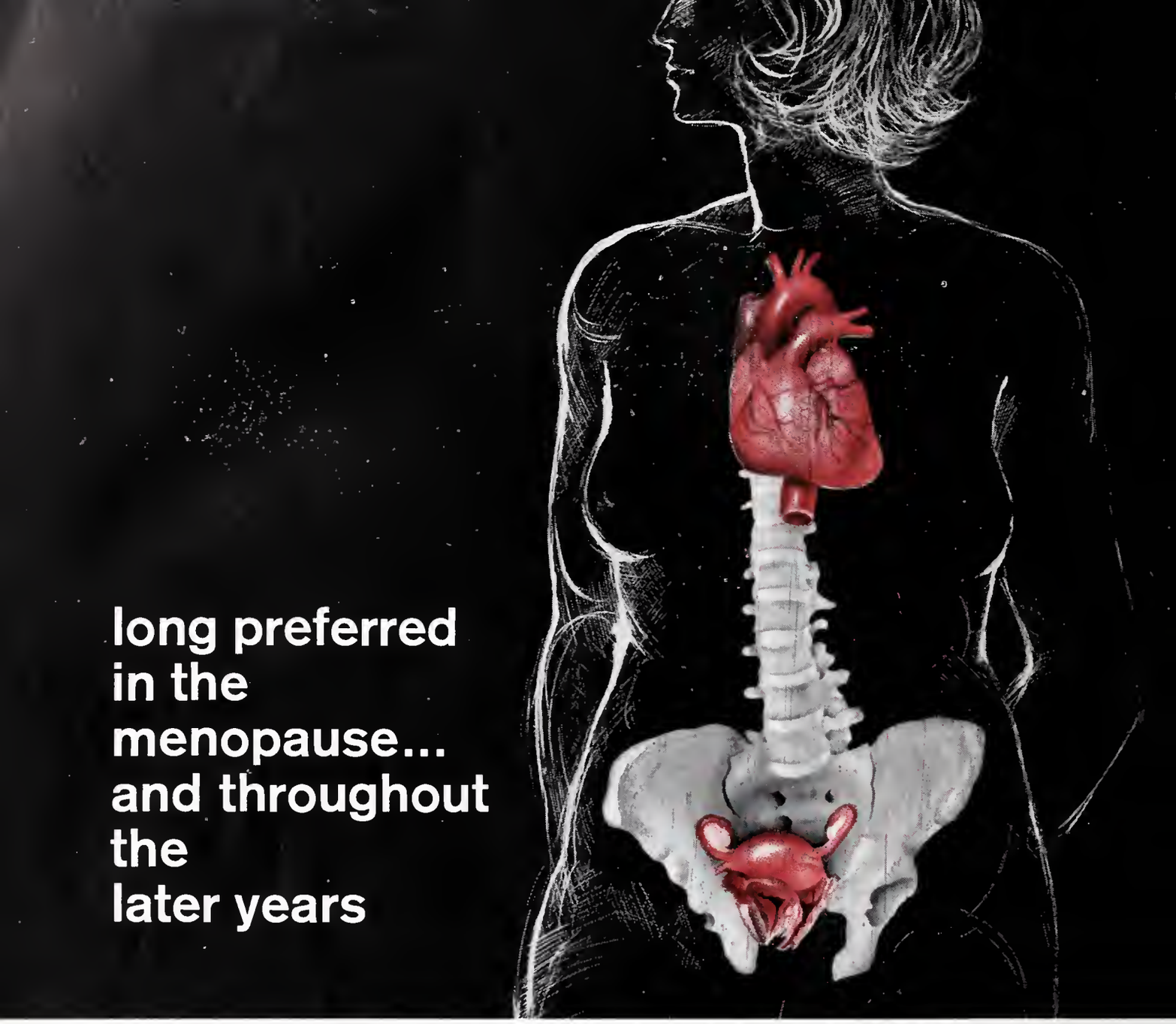




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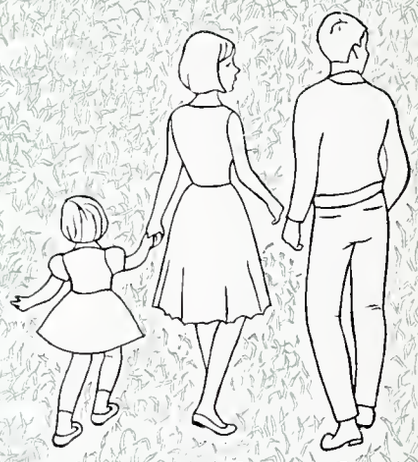
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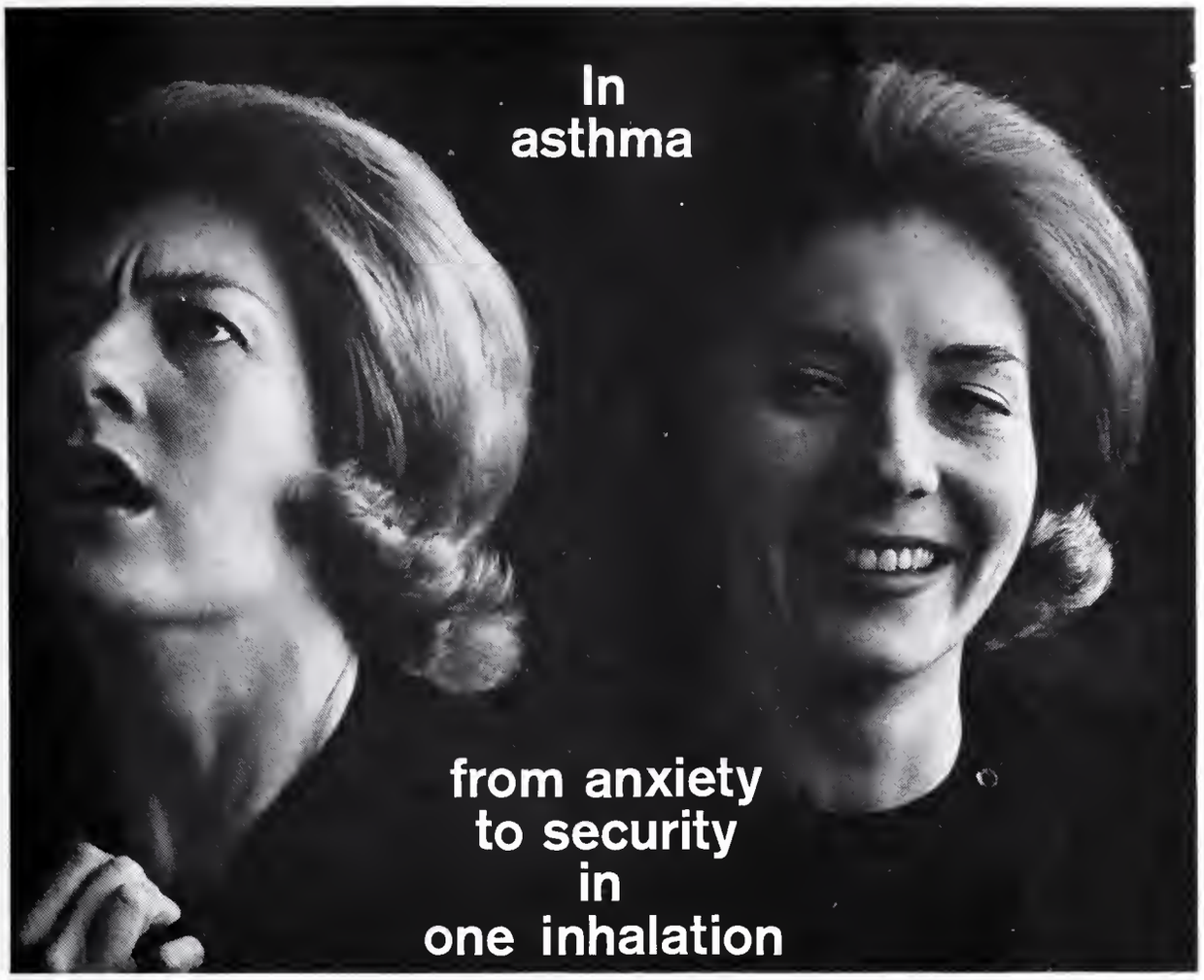
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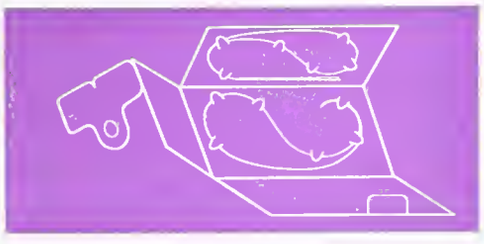
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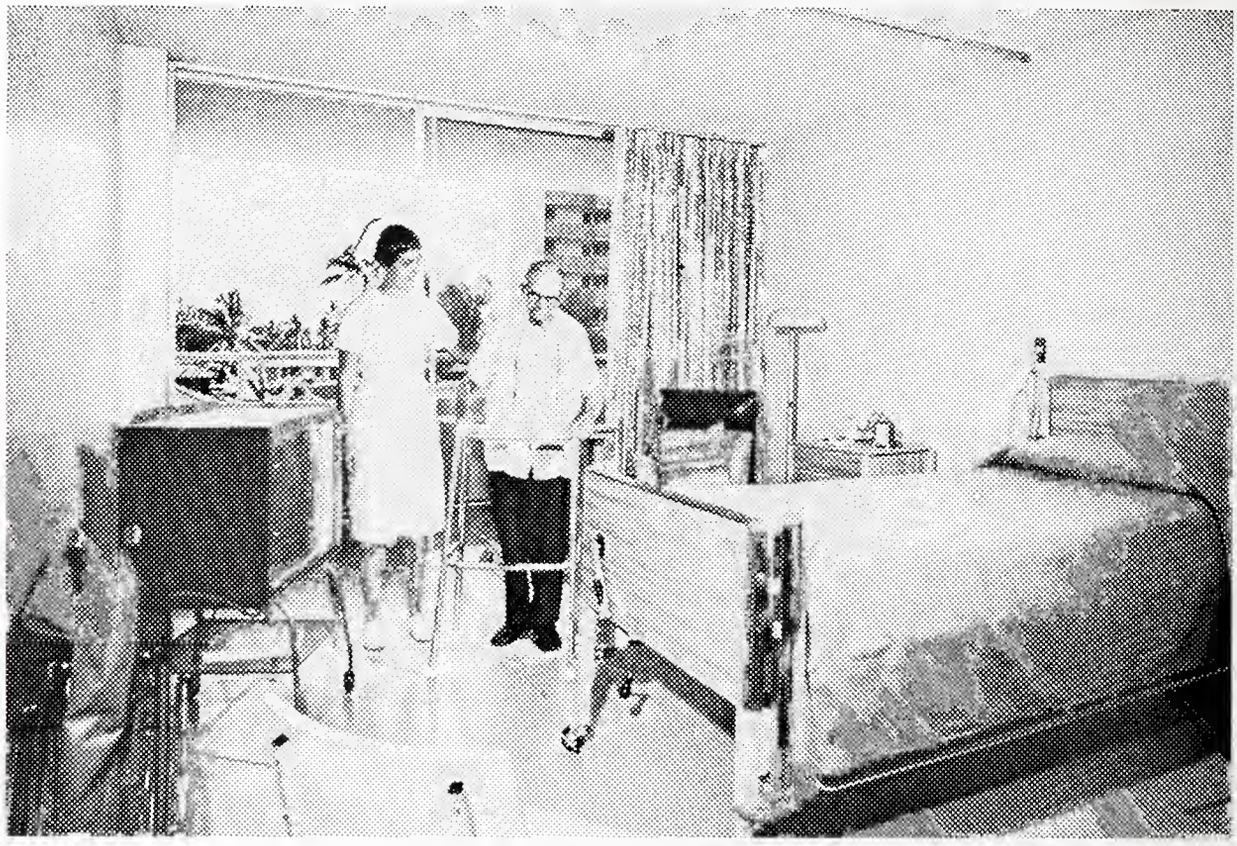
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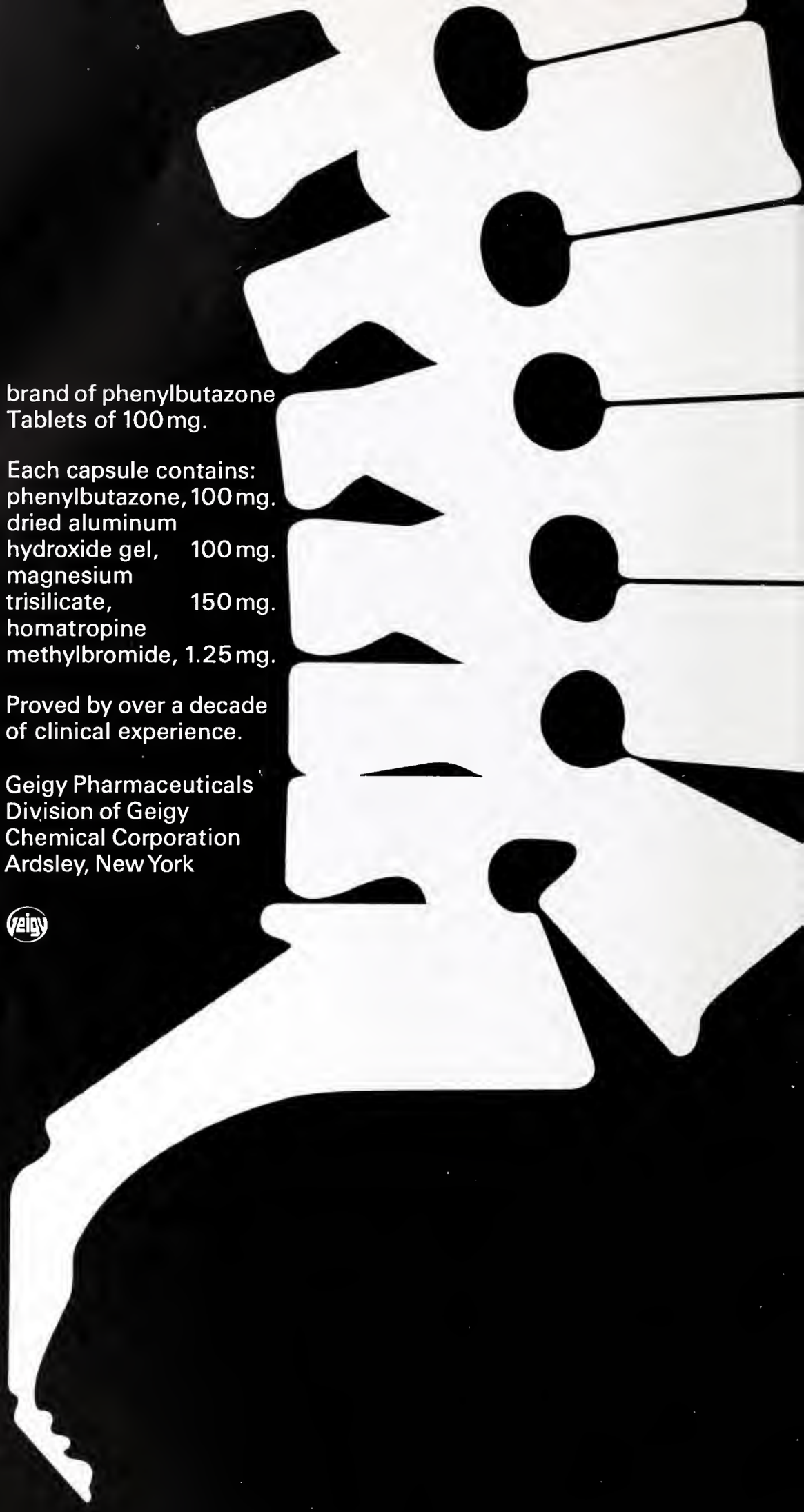
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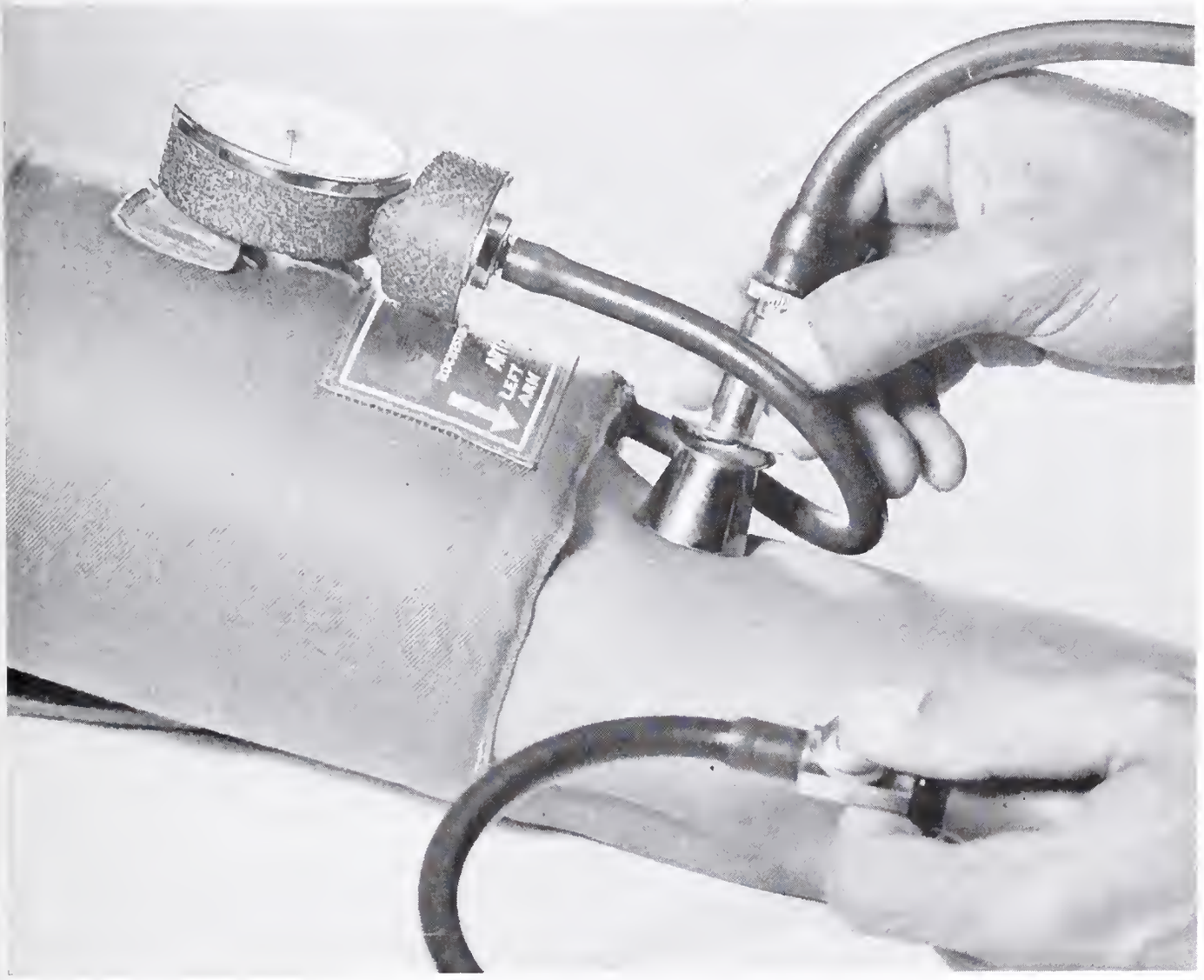
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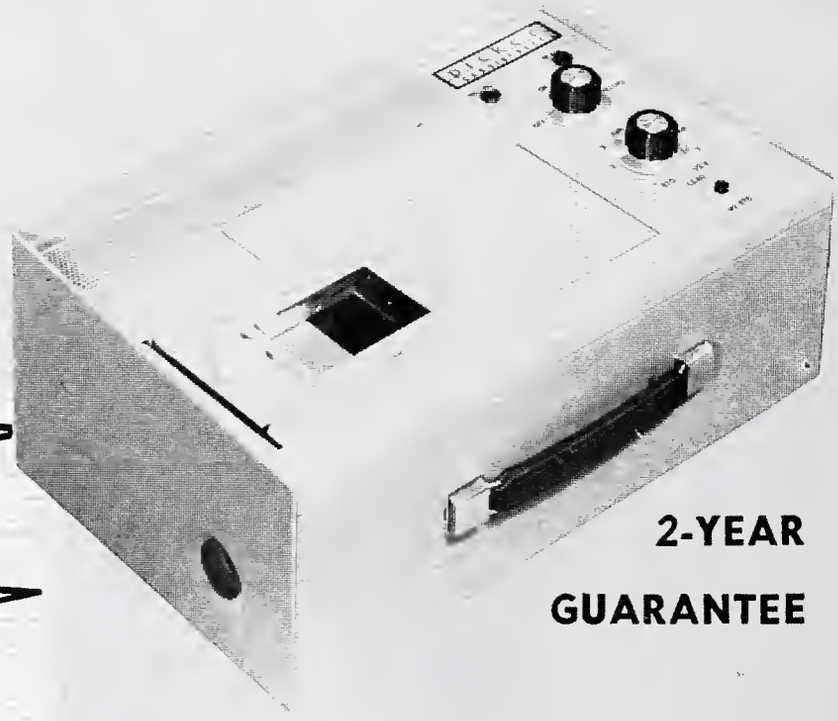
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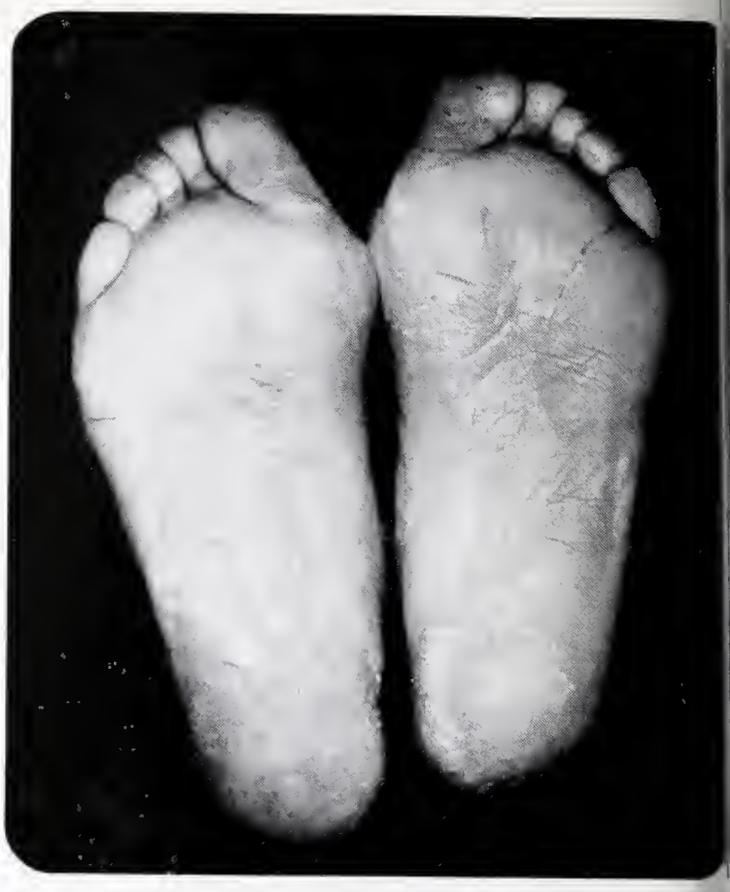
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INDICATIONS: DONNATAL is indicated in recurring, persistent or chronic visceral spasm, as in peptic ulcer, pylorospasm, irritable stomach and colon, motion sickness, nocturnal enuresis, mucous colitis and diarrhea.

SIDE EFFECTS: No serious toxic reactions are to be expected. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage.

PRECAUTIONS: Patients with incipient glaucoma or urinary bladder neck obstruction must be treated with care, as with any preparation containing a parasympathetic depressant.

CONTRAINDICATIONS: DONNATAL is contraindicated in acute glaucoma, advanced hepatic or renal disease, and known or suspected idiosyncrasy to any of its components.

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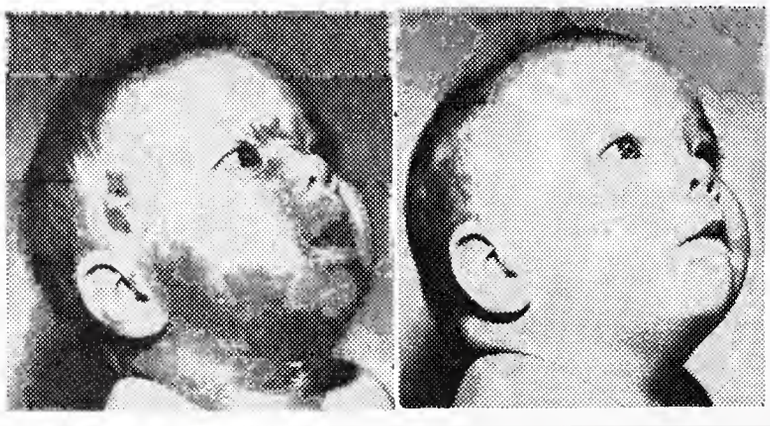
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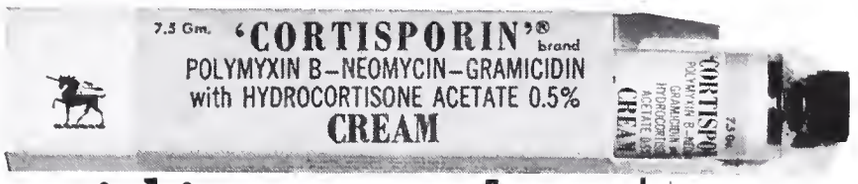
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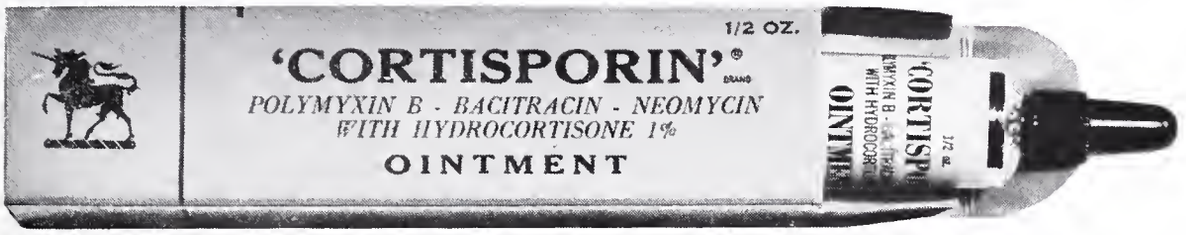
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HAWAII MEDICAL JOURNAL

Reports & Snorts

The ordinary run-of-the-mill shooting star you see in the night sky was a pea-sized piece of rock which entered the atmosphere at around 25 miles a second—*plus* the earth's orbital velocity of 18.5 m.p.s. after midnight, or *minus* it before—and is burning up in a ball of flame a foot or two in diameter because of air friction. So says Fred Whipple, approximately.

• • •

Desferrioxamine is an iron-chelating agent, obtained from Streptomyces pilosus, which has been used successfully orally to combat poisoning by an oral overdose of iron, and parenterally to combat iron poisoning in multiply-transfused victims of Cooley's anemia.

• • •

The Liaison Committee of the Association of American Medical Colleges and the AMA's Council on Medical Education and Hospitals suggest that a two-year medical school should be considered only (1) if it is the beginning phase of a soon-to-be-started four-year school, or (2) if it is developed by a strong university with a vigorous graduate program in the biological and social sciences.

—WICHE Forum, 1963

• • •

Hottest topical corticosteroid: Synalar Solution 0.01%—fluocinolone acetonide in propylene glycol. Greaseless, hygroscopic, stainless, economical, easily applied, it comes in plastic squeeze bottles, 20 cc. or 60 cc.

• • •

Schering was awarded U.S. patents on prednisone and prednisolone in May, after ten years of litigation. They promise a "liberal licensing policy."

• • •

Blockade of catecholamine synthesis for control of hypertension looks like a better possibility now that NIH researchers Levitt, Nagatsu, and Udenfriend have reported isolation of the enzyme—L-tyrosine hydroxylase—that converts tyrosine to DOPA, the first step in the natural synthesis of norepinephrine.

The FDA in May put out of business a fly-by-night firm that had started to manufacture meprobamate without registering with the FDA and permitting inspection of its premises.

• • •

Flour particles in "instantized" flour have been processed into tiny clusters or granules; new FDA requirements proposed for them are that they must all pass a No. 20 mesh sieve (840-micron openings) and not over 20 per cent will pass a 200-mesh sieve (70-micron openings). Ordinary flour must pass a 100-mesh sieve.

• • •

Kerosene and gasoline cans must bear proper labels or they cannot legally be filled; the filling station must apply a label before filling your unlabelled can. Ask them to do it.

• • •

Coty (Pfizer) has joined Hazel Bishop and Helene Curtis: a quantity of "Line Away Temporary Wrinkle Smoother" was seized by the FDA in Delaware in May because it isn't recognized as safe and because exaggerated claims were made for it.

• • •

Want a new otoscope with a unique fiber-optics illumination system? Welch Allyn has just announced one. Fits their standard battery handle and No. 2 otoscope lamp.

• • •

Maybe pentazocine, a benzomorphan derivative, is the new, safe, non-addicting morphine substitute we've been waiting for (JAMA, April 13). It is still in the experimental stages.

• • •

In 18th century England, carving was too important to be designated with just this one word. The word for it depended on what was being carved. A turkey, a capon, a (you should excuse the expression) bustard, or a pheasant was *cut up*. A partridge or quail was *winged*. You would *allay* a pheasant or teal, *lift* a swan, *display* a crane, *dismember* a heron, *thigh* a woodcock, a curlew, a plover, or a snipe; *rear* a goose, *unbrace* a mallard or a duck, or *unlace* a rabbit.—*The London Art of Cookery*, by John Farley, London, Scatcherd and Whitaker, 1789. ■

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INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

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CONTRAINDICATION: Anuria.



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CURRENT CONCEPTS IN THE TREATMENT OF EMOTIONAL DISORDERS

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Sunday, October 11, 1964

8:30 a.m.–4:15 p.m.

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PROGRAM

8:30–9:15 A.M. *Registration*	**Sheraton Meeting House**
9:15–9:30 A.M. *Welcome*	**Robert P. C. Ho, M.D.**
9:30–10:15 A.M. *A Useful Guide in the Classification of Psychotropic Drugs*	**Thomas Detre, M.D.** *Director, Inpatient Psychiatric Services* Yale Medical Center, New Haven, Connecticut
10:15–11:00 A.M. *The Masks of Depression*	**Paul E. Feldman, M.D.** *Director of Research and Education* Topeka State Hospital, Topeka, Kansas
11:00–11:45 A.M. *Recognition and Treatment of Anxiety*	**Burton Cahn, M.D.** *Consulting Psychiatrist* University of Pennsylvania Medical School Philadelphia, Pennsylvania
12:00–1:45 P.M. *Luncheon for Doctors and Their Wives*	Speaker to be announced
2:00–2:45 P.M. *Functional Gastrointestinal Disorders*	**Howard E. Ticktin, M.D.** *Chief Medical Officer* The George Washington University Medical Division D. C. General Hosiptal, Washington, D. C.
2:45–3:30 P.M. *Recognition and Treatment of Alcoholism*	**Martin D. Kissen, M.D.** *Clinical Director* Institute for Alcoholism & Narcotics Addiction St. Luke's Hospital, Philadelphia, Pennsylvania
3:30–4:15 P.M. *Questions and Answers*	By the entire panel

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Be not disheartened—perhaps our patients no longer love us, but in time they may respect us!

The Image of the Physician

ROBERT E. TRANQUADA, M.D.,* *Los Angeles*

• *Why does the modern physician, who has more to offer his patient than did the horse-and-buggy doctor, reap complaints, ill will, and malpractice suits, instead of affection? Dr. Tranquada suggests it may be because science is replacing art in medical practice. Moreover, he believes all of us—doctors and patients alike—will ultimately readjust to the "new look."*

DR. ARTHUR HERTZLER, in his book, *The Horse and Buggy Doctor,* describes the treatment of typhoid fever: "Under certain conditions the doctor was able to be of some service. When the stage of high temperature and delirium was reached, cold sponging was demanded, or at least that was the consensus of professional opinion at that time. There being no trained nurse, it fell to the doctor's lot to do the job. It usually required one to two hours of sponging to reduce the temperature to 103°. One was rewarded for his efforts by seeing the patient sleep peacefully, free from muttering, for several hours."[1]

In another passage, he describes his own reaction to the ministrations of a physician: "In the saddest hour of my life, at the deathbed of my daughter, on one side was the magnificent and always faithful Carrie, the nurse, on the other side the incomparable Dr. Campbell, calmly applying measures of resuscitation which he and I knew were utterly futile. Yet futile though it was, the battle of these professions inspired an indescribable measure of comfort . . . if my presence in a similar situation ever brought an equal amount of comfort to anyone, I am sure it was more worth while than anything else I have ever done."[2]

* Assistant Professor of Medicine, University of Southern California School of Medicine, Attending Physician, Los Angeles County Hospital.

Received for publication February 4, 1964.

THE MODERN VIEW

Contrast those descriptions with the following: The highly trained physician interprets the results of a tuberculin skin test which he gives annually to his patients. A young mother of four self-consciously offers her forearm for examination, and there can be seen a red, circular raised area suffused with the blush of inflammation and showing the evidence of vigorous scratching. A quick glance at the records reveals the significance of the test: one year ago, a similar skin test had been negative. The conclusion: At some time during the year this young woman has been infected with tuberculosis and the evidence of that fact is now visible on the outstretched arm.

Quickly the x-ray request is written out, the appointment made for the next office visit two days hence, and the physician goes on to the next examining room to assay the effects of the recent radioiodine therapy on its occupant's hyperthyroidism.

Two days later, the frightened young woman and the x-ray report await the doctor in the same consultation room. The result is just as clear as the skin test was two days previously. "A postero-anterior view of the chest," reads the radiologist's report, "reveals normal bone structure and ear-

diovascular silhouette. In the mid left lung field is a hazy density one-third of an inch in diameter, associated with some increased vascular markings in the area and enlargement of the left hilar lymph nodes." Primary pulmonary tuberculosis.

The diagnosis is announced, prescriptions for para-amino-salicylic acid and Isoniazid are written, brief instructions given and a one-month return appointment made. And, oh yes, would Mrs. H. be sure to have her husband and children report to the radiologist within the week for full-sized chest x-rays?

WHO DID MORE?

How do these incidents of past and present medicine differ with respect to outcome? The typhoid victim was more comfortable for a few hours following the doctor's efforts, and the following morning, just before the doctor was to take his leave, the patient perforated his intestine, became comatose, and died within the hour. Dr. Hertzler, himself, describes the futility of the vigil with his daughter. She died. What was accomplished in either case that could not have been done as well in the absence of the physician?

What about young Mrs. H.? A year of continued INH and PAS therapy is recommended and followed. The lung lesion rapidly clears. The x-rays of her husband and children are normal, and repeated skin testing and x-rays of them remain negative. Mrs. H. has not been ill. No one could convince her that she has been, for after all, she has not changed in appearance, nor has she noted any of the symptoms of illness. She has not even lost additional weight, although obesity was her original reason for coming to see the doctor.

What has been accomplished? An early, asymptomatic case of tuberculosis has been detected and appropriate therapy has been successful. The possibility that her family might have been infected was eliminated. The possibility that she herself might have been taken from her family to stay for months in a tuberculosis sanitarium has been eliminated. A great deal has been accomplished.

How do the responses of these patients and their families differ? The family of the man who died of typhoid were eternally grateful to the doctor. Had he not ridden, on horseback, seven miles to see his patient? Had he not been available and willing to come when called? Had he not used all the means at his command to ease the suffering of their poor father? Indeed, was he not present and ministering to the patient throughout the most critical period of the fatal illness? Had he not given of his time and his understanding counsel? Two months later two children of the family died of the same disease, contracted from the same contaminated well water, which the doctor could not have warned them of—the information simply was not available. Yet, the familiar presence of the doctor and his willingness to serve their suffering were rewarded by the family with reverence and devotion.

The family of Mrs. H.? Two of the children have had to miss school to make their x-ray appointments. Mr. H has been presented with a sizable bill for six chest x-rays, a year's worth of not inexpensive medication, and a moderate bill from the physician for the role he has played. What does the H. family think of the doctor? Well, he probably knows his business, all right, but how does he think he can get away with a bill that size for the little time he actually spent with his patients? He didn't even make a house call.

What has happened during the interim to the image of the physician? What is responsible for this paradoxical contrast of the reactions of patients to their physicians in such a short span of time? Three dimensions—the patient, the doctor, and medicine itself—colored deeply with time, moral climate, and custom, go into this portraiture, from which emerges the image of the physician, and which alternately produces exclamations of approbation and criticism.

WHAT DO PATIENTS WANT?

The patient, God bless him, the ultimate target of all our learning—has he changed? Has he somehow become wiser and more perceptive about his doctor? In 1871, Oliver Wendell Holmes said to a graduating class at Bellevue: "In the first place, the persons who seek the aid of the physician are very honest and sincere in their wish to get rid of their complaints and, generally speaking, to live as long as they can. However attractively the future is painted to them, they are attached to the planet with which they are already acquainted. They are addicted to the daily use of this empirical and unchemical mixture which we call air, and would hold on to it as a tippler does to his alcoholic drinks.

"There is nothing men will not do, there is nothing they have not done, to recover their health and save their lives. They have submitted to be half-drowned in water, and half-choked with gases, to be buried up to their chins in earth, to be seared with hot irons like galley slaves, to be crimped with knives, like cod-fish, to have needles thrust into their flesh, and bonfires kindled on their skin, to swallow all sorts of abominations, and to pay for all this, as if to be singed and scalded were a costly privilege, as if blisters were a blessing, and leeches were a luxury. What more can be asked to prove their honesty and sincerity?"[3]

To the physician of fifty years ago, the patient's problem was relatively closely related to his complaints, and Dr. Hertzler comments: "Patients are grateful in proportion to the relief obtained, even though the condition does not threaten life."[1]

Today, the patient who complains of headache is treated for hypertension, something he can neither see nor feel; the patient who complains of simple obesity is treated with painful daily injections for diabetes, just as invisible to the patient's eyes as hypertension.

Is the patient of today wiser? Certainly he is more sophisticated. He is less likely to believe that his heart can actually turn over or that warts are caused by playing with toads. He is the subject of a mass educational effort on television, radio, and even in the public schools, in which modern concepts of physiology and medicine are frequently brilliantly expounded. He is also the avid reader of those great medical journals, *The Readers Digest, Time,* and *The Ladies Home Journal,* among others.

"LIFE EMANATIONS" MACHINE

And yet in the middle of all this sophistication and scientific education, strange things happen. In Los Angeles, within the past few months, the operators of a health clinic were finally indicted by State authorities after many years of practice. They had a marvelous machine, profoundly simple and effective. The patient simply donated a small blood sample, which was placed in the machine, which then glowed confidently with multicolored lights, dials, switches, and knobs. No time-consuming examination was required. The machine (obviously a far-advanced scientific, modern concept) did all the rest. The "life emanations" from the patient were registered forever on the memory of the machine. If at any time the donor of the blood specimen were to become ill, at home or abroad, a simple telephone call, cable, letter or telegram (if followed closely by a money order), describing the symptoms, would result in the blood's being placed back in the machine, the life emanations re-coded to the machine, vibrations thence emanating from the machine to the patient in pain, discomfort, gaseousness, shortness of breath or whatever, and a cure effected.

The very same people who swallowed this one, and had to be rescued by a protective agency of the State, are no longer startled or curious about the miracle of atomic power, the curative effects of open heart surgery, or the orbiting of five tons of delicate and advanced instruments about this planet.

What unites the simple patient of the mid-nineteenth century with his more sophisticated heirs of a hundred years after? The desire to be relieved of discomfort—no more. No one but the ill-prepared schoolboy, the ill-prepared public speaker, or the teen-aged boy setting out for his first date, wants to be told he is sick and must stay home. Loss of the state of health or physical comfort or ability is a serious matter, and any remedy, not excessive in cost and not violating too much a man's credulity, is acceptable if it provides or seems to provide relief from real or imagined discomfort.

THE AIM IS THE SAME

Thus the basic motivation of today's patient in seeking medical advice does not differ from that of the patient of 100 or even 1,000 years ago. Wherein do the patients' responses to the physician differ? The modern patient is aware of "miracle drugs," "miracle operations," fantastic diagnostic devices, and amazing therapeutic successes. He is told about them by his friends, television, newspapers, radio, and sometimes by invisible emanations from the atmosphere. He *expects* to be relieved, cured, improved, and restored to health, and of course, at minimum cost.

The physical presence of the physician alone is no longer sufficient to ease suffering minds. He must bring his diagnostic skill, his laboratory, his knife, and his pills, and he must use them correctly. Let a misdiagnosis, an error in judgment, a crooked bone, or a less-than-perfect scar occur, and the courts are waiting to provide retribution to the injured patient—who might not have been aware of his serious condition without the aid of his physician, or whose very life (in spite of the crooked bone) may have been granted to him by this man's skill.

What of medicine? Wherein has it changed in the past century? Are not its first goals still the relief of suffering and the dedication to the interests of the patient? In this respect, medicine has not changed. In many other repects it has. Much of medicine—the annual physical examination of the well patient, the frequent examination of the well baby, the normal pregnancy, the routine chest x-ray, the Papanicolaou test for cervical cancer—is dedicated to the detection and prevention of potential hazards to the patient.

But how can one equate the prevention of potential suffering with the relief of obvious, painful, discomforting, palpable, and present suffering? "Be glad and respectful," says the doctor, "because I just prevented you from having cancer. $35, please." "Be respectful yourself," says the patient, "I felt perfectly well all the time and now I have a disfiguring scar on my breast—$35,000, please."

SCIENCE EMERGES FROM ART

Medicine is slowly becoming a science. Formerly ninety-five per cent art and—generously speaking—five per cent science, the practice of medicine may now approach being ten per cent science. Moreover, the tools and methods of our trade have been sharpened, honed, adjusted, focussed, and increased manyfold in efficiency. In fact, we find ourselves with an armory of two-edged swords.

In the past, the undiagnosed angina pectoris was just as responsive to the same useless, complicated prescription as was the neurotic's chest pain. In the present, the achievement of diagnostic accuracy and therapeutic efficiency has borne with it the inseparable responsibility on the part of the physician to recognize all of the hazards of his new abilities.

The diagnostic sternal bone-marrow aspiration has led to cardiac puncture. Estimation of circulation time has led to fatal sensitivity reactions to Decholin, as have injections of contrast material for kidney x-rays, angiograms, and aortograms. A test for adrenal insufficiency, the administration of ACTH, and a similar test for the origin of hypothyroidism—the administration of TSH—have led to fatal reactions in the attempt to diagnose what are known to be curable diseases.

Life-saving and discomfort-relieving drugs, if potent enough to produce objective effects, are often potent enough to produce other unwanted effects. Digitalis—the invaluable drug for a patient in heart failure—can, and frequently does, cause increased heart failure, and even death. Powerful tranquilizers produce liver disease. Our most efficacious antibiotics are occasionally responsible for sensitivity reactions, liver disease, agranulocytosis, aplastic anemia. The friendly x-ray which melted away tonsils formerly requiring surgical intervention, has become the deadly enemy which has increased the rate of thyroid cancer and leukemia in patients it has aided in other respects.

More and more time and effort is demanded of the physician to maintain old and add new skills. Constant awareness of the hazards associated with the practice of modern medicine is required. Expenses to the patient have risen. Radioisotopes, specialized drugs, modern electronic machinery, radiological techniques, fantastic accomplishments of the clinical laboratory, and the requirement for the services of highly trained technicians, both at bedside and instrument-side, represent investments of time and money which must be repaid.

What about the modern physician? Wherein does he differ from his predecessors and wherein does he remain unchanged? The practice of medicine has been greatly altered by the tremendous scientific advances of our century, and many more changes are likely to occur. However the primary goals of the physician remain unchanged—to relieve the suffering, real or imagined, of the patient. Only the emphasis is changing, from the relief of present pain, to the prevention of future discomfort and illness. This change at once represents a major alteration in the emphasis of the practitioner and a high hurdle to the understanding of the layman.

The following came to my attention recently: "Give me strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend infinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he may obtain a new light on what he thinks himself sure of today."[3] Sound familiar? A modern observation? The words are those of the great Jewish physician, Maimonides, written during the twelfth century AD. Thus the task of the daily acquiring of new knowledge is not newly assigned to the physician of today. The volume of that knowledge has changed, however.

BEWARE OF USELESS RESEARCH

Never before have significant contributions to the practice of medicine been offered in such volume. Neither have so many useless, inaccurate, and incomplete observations ever been offered. Thus the practitioner is faced with the problem not only of absorbing volumes of new medical knowledge, but of sorting and evaluating that which comes his way, to sift the kernels of truth from the chaff of inaccuracy and misinterpretation.

We come to a paradoxical and difficult problem confronting the modern practitioner and deeply tinging his public image: If the physician is to acquire a significant store of accurate information, apply his information and skills accurately and knowledgeably to the ills of mankind, and with precision and objectivity to diagnose and treat previously undiagnosable and untreatable diseases, when and where could he find the time to ride horseback seven miles in the rain to his patient's bedside, maintain hours of vigil doing nurses' work, and provide that understanding and confidence which was the sole stock in trade of the physician not too many years ago?

It is clear that the ready availability of rapid transportation and the far superior equipment of the office and hospital over the home have made the majority of house calls unnecessary and inefficient. The doctor who says, "Meet me at the office," at 3 A.M., is not maintaining the same image as he who says "I'll be right out to your house." Yet, the office being far better equipped,

the patient's visit there is far more likely to lead to a successful conclusion than is the doctor's house visit.

The physician is faced by another problem. The patient, whose confidence in miracle drugs and whose general knowledge of health science has markedly increased in recent years, is taking advantage of the availability of his physician more and more frequently for complaints which, only a few years ago, would have been treated with home remedies or ignored. This means that the number of patient visits has increased and the time available for each patient has significantly decreased. The office chat, the leisurely house call, both are expensive of the doctor's time. The patient who desires primarily a confidant or counsel is frequently disappointed in the response of the doctor if no physical ailment is found. Here the image of the physician especially suffers, in comparison with the memory of the horse-and-buggy doctor.

THE CHANGE IS DESIRABLE

The changing image of the physician is a wholly justifiable and desirable phenomenon. The change is born largely of scientific accomplishment, nurtured by a laity at once more sophisticated scientifically and yet often gullible in matters related to health, and cradled on the solid oak of an unchanged and unchanging concept of the responsibility of the physician to his patient.

The image is changing, and the aftertaste of the change is bittersweet. It is disappointing to both physician and patient to observe the gradual fading of the romantic vision of the genial confidant, whose friendship, time, and counsel were his primary virtues. Such an image will continue to fade, but will not entirely disappear, and in its place will gradually appear the outlines of the objective scientist whose image is at present merely outlined and whose complete visage will require many more years to complete.

In the meantime, and for many years to come, physicians and patients will feel the pangs of regret at the fading of the old image. This will, from time to time, interfere with the professional relationships between the two. What perspective can we take at present, and what aid can we furnish which will lessen the sense of loss at the fading of the old masterpiece? Dr. Hertzler again offers his wisdom: "From what has already been said, it is clear that the country doctor's activities had less to do with the saving of life than with relieving a patient's pain and the mental suffering of the family.

"Whatever one may conclude in retrospect as to the importance of the doctor's ministrations, neither doctor nor patient then doubted the efficacy of the treatment employed. However, the picture must not be painted unduly drab. The patient's sufferings were relieved and in occasional cases the measures employed were unquestionably life-saving. Let it be remarked that, exalted as are the achievements of the present day, the younger man may well remember that possibly fifty years hence his achievements may seem as puerile as ours do now. Furthermore, what concerns the individual doctor is not so much what medical science can achieve as how much of this he can deliver to his patients. That is the personal element for which each doctor is responsible."[5]

As long as we remain true to the art and science of our calling, responding always to the principal precept that our sole concern is for the patients' welfare, and our primary dedication is to translate the best of medical knowledge into the most practical application to our patients' requirements, both present and future, our image may temporarily dim and grow blurry to the eyes of the public, but will be replaced eventually with the true portrait of dedicated professionals.

As Maimonides said so well, "The Eternal Providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all times; may neither avarice, nor miserliness, nor the thirst for glory, nor for a great reputation engage my mind; for the enemies of Truth and Philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children." ■

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An intermittently painful persistent or intermittent swelling in a lower abdominal quadrant may be a Spigelian hernia.

Spigelian Hernia Occurring in Conjunction With an Inguinal Anatomical Defect

Report of a Method of Closure

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• *This report concerns the occurrence of a Spigelian hernia in a patient with an anatomical defect of the inguinal floor. A technique of repair is described that can be applied to direct inguinal hernias developing in individuals with similar inguinal defects or, for that matter, to any type of direct inguinal hernia. A definite correlation between the occurrence of musculo-aponeurotic defects of the internal oblique and transversus abdominis muscles and the development of a Spigelian or semilunar hernia is suggested by this case.*

SPIGELIAN, semilunar, or lateral spontaneous ventral hernias are defined as hernias occurring through the aponeurosis of the transversus abdominis muscle lateral to the rectus muscle, at or near the junction of the linea semilunaris and linea semicircularis. The most plausible etiological factors at present are hiatus of vascular perforations of the linea semilunaris and or the occurrence of fusiform musculo-aponeurotic defects of the internal oblique and transversus muscles.

Obesity, trauma, pregnancy, and weakness at the junction of the semilunar and semicircular lines have been advanced as probable causes of this type of hernia. Wakely and Childs,[10] Bailey,[2] and Leis, Mersheimer, and Winfield[5] have described cases in which vessels have been noted passing through the hernial ring or have been closely associated with the neck of the sac. In a recent anatomical study of 500 inguinal body-half dissections, Anson, Morgan, and McVay[1] have shown a 22 per cent incidence of a fusiform musculo-aponeurotic defect of the internal oblique muscle above and below the internal inguinal ring. They have also shown a 13 per cent incidence for the same type of defect in the transversus abdominis in 100 dissections. Previously Zimmerman, Anson, Morgan, and McVay[11] had indicated a 10 per cent incidence of a banding of the internal oblique and transversus abdominis muscles to produce a defect frequently located in the region of the semiluminaris. Bailey[2] reports a case in which he observed this banding as contributing to the occurrence of the Spigelian defect.

ETIOLOGY

The longitudinal site of the hernia depends on the anatomical level of the linea semicircularis, which is subject to considerable variation. Most of these hernias occur in the area between the anterior superior iliac spine and the internal inguinal ring. This is the same area in which most of the musculo-aponeurotic defects of the internal oblique and transversus muscles occur.

Perrigard[8] has divided these hernias into two types—those occurring above the inferior epigastric arteries and those occurring medial to and below this vessel; those occurring below the inferior epigastric artery have also been referred to as a diverticular form of a direct inguinal hernia.

A total of 175 cases was found in the world literature by Leis, Mersheimer, and Winfield in 1958. Bailey in the same year reported four more. A review of American, British, and Canadian literature up to December, 1960, shows an addi-

Received for publication January 8, 1964.

tional 20 cases reportedly G. T. Paul[7] (1), T. J. Miller[6] (2), M. S. Harless and J. E. Hirsch[4] (9), and R. C. Read[9] (8). Inclusion of this case would bring the total, in the literature reviewed, to 200. Undoubtedly these hernias occur more frequently than the literature would indicate.

Diagnosis of the semilunar hernias will rest in a measure upon clinical awareness of their existence. The usual history is one of cramping pain in the area of the hernial defect. Occurrence of this pain in a hernia without incarceration will usually be intermittent and related to posture, the pain usually subsiding when the patient is recumbent. An ill-defined, nontender, painless swelling may be the initial complaint.

DIAGNOSIS

Occasionally the patient is one in whom a complete gastro-intestinal work-up, including x-rays and proctoscopy, has been carried out in an effort to determine the cause of pain. In these instances, the hernial defect may escape detection because of the position of the patient on examination or the ill-defined nature of the hernial protuberance. The clue in these instances is the consistent localization of the pain to the area of probable herniation. Close examination of these regions with the patient erect will usually demonstrate the suspected hernia. In some instances coughing and straining will obscure the hernia through contraction and tension of the external oblique aponeurosis. This subfascial location will also account for the patient's history of pressing in the area of pain and feeling gaseous crepitation of the bowel but of being unable to describe a definite lump.

CASE REPORT

A 52-year-old Caucasian priest seen in January, 1962, gave a history of a lump in the right lower quadrant of two months' duration. The lump was associated with occasional dull pain and was not apparent when he was recumbent. It could be reduced with pressure over the area. The patient noted that it was near an old appendectomy scar. He could not associate the onset of this lump with any trauma or unusual physical activity. His past surgical history included an appendectomy in 1938 and a cholecystectomy in June, 1961.

On physical examination the patient was a well-developed man with a moderately thick ventral fatty panniculus. A surgical scar of the Mayo-Robinson type was present in the right upper quadrant and a McBurney type oblique appendectomy scar in the right lower quadrant. A palpable, reducible lump could be felt caudad and medial

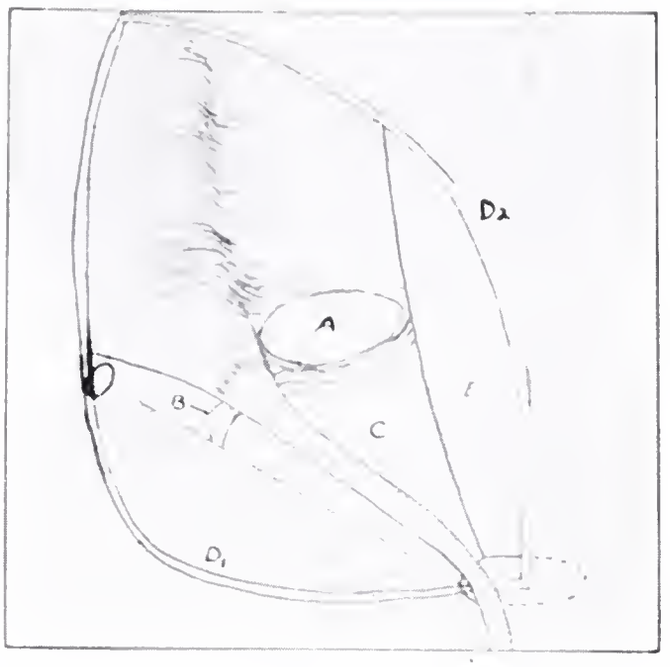


FIG. 1.—*Demonstration of the hernia defect: (A) Epigastric vessels, (B) The inguinal floor defect is identified below the epigastric vessels, (C) The external oblique aponeurotic flaps (D_1 and D_2) and the rectus sheath (E) are shown.*

to the appendectomy scar. Palpation of the internal inguinal ring demonstrated no hernia. A definite ventral hernia defect could be outlined just above and medial to the internal inguinal ring, extending to what appeared to be the lateral border of the rectus muscle. The appendectomy scar was firm and no continuity with the described defect could be demonstrated. The possibility of a Spigelian hernia was entertained and the patient was advised of the desirability of surgical repair.

On March 1, 1962, the patient was operated upon under general endotracheal anesthesia. A portion of the appendectomy scar was excised and the incision carried obliquely and medially over the hernia site.

The external oblique fascia was divided in the direction of its fibers and the underlying structures exposed. A lump of fatty tissue protruded into the wound medial and cephalid to the internal ring. This mass was identified as the hernial sac, presenting through a 4 x 5 cm defect of the most distal fibers of the internal oblique muscle. The inguinal floor was devoid of any muscle or aponeurotic structures. The inferior epigastric artery and vein were distal to the hernia and appeared to have been caudally displaced by the hernial sac (Fig. 1). The sac itself was empty at the time of surgery. Palpation of the inferior peritoneal surface of the appendectomy scar through the opened sac demonstrated no continuity with the lateral margin of the hernial ring.

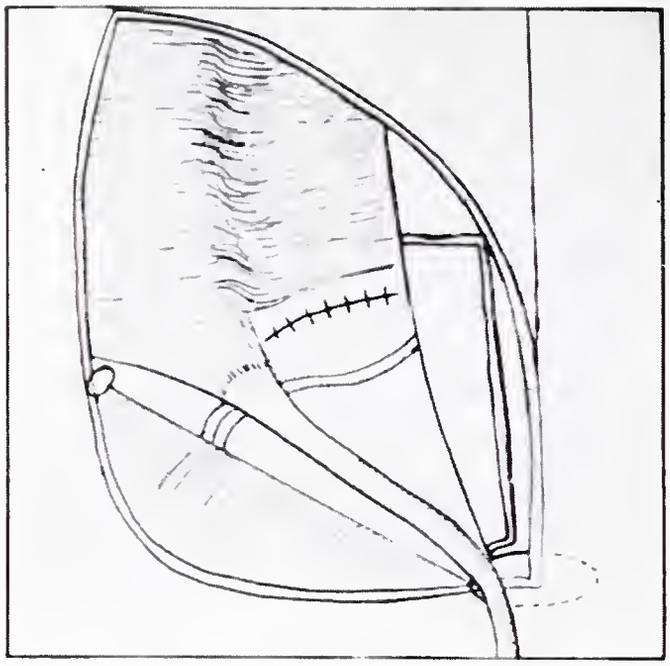


FIG. 2.—*The hernia defect has been closed and a rectus sheath flap developed (E).*

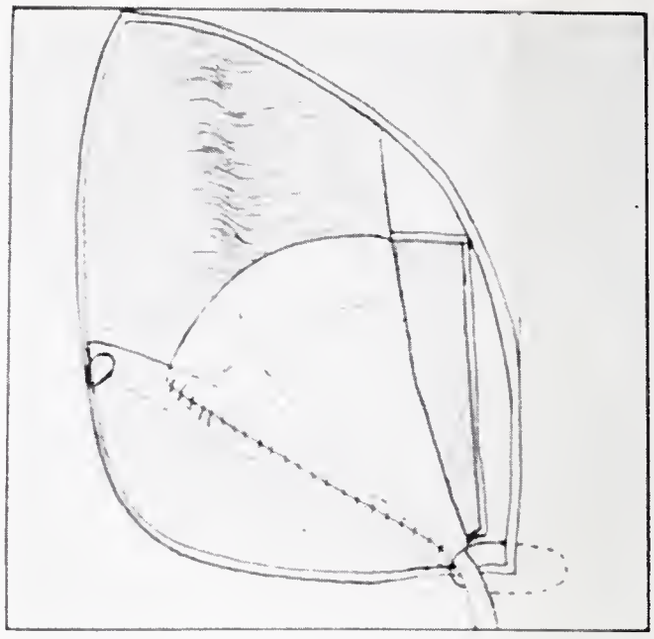


FIG. 3.—*The rectus flap has been brought over the inguinal floor defect and Spigelian defect, and is shown sutured to the inguinal ligament over the cord structures, creating a new external ring.*

The repair consisted of excision of the redundant sac and a transverse closure of the defect.

At this time it was noted that the transversalis fascia in the area of the hernia and the inguinal floor was practically nonexistent. The superior margin of the defect was composed of reasonably firm transversus abdominis aponeurosis. Inferiorly, the fibers of the internal oblique and transversus aponeurosis were so attenuated as to be of little structural value in the closure.

Closer observation of the inguinal floor medial and inferior to the epigastric vessels confirmed the congenital absence of internal oblique, transversus, and transversalis musculo-aponeurotic structures. Bowel could be visualized through areas of translucent peritoneum. A large rectus flap was turned laterally to cover the hernia site and inguinal floor. The cord was not disturbed and the flap was sutured without tension fairly high on the inguinal ligament just above the cord, making a new external ring in the process.

REPAIR OF DEFECT

The distal rectus aponeurotic border appeared quite weak at the conclusion of this procedure and seemed to be the potential site of a recurrent hernia. A method of repair as illustrated in Figures 2 through 5 was then devised. The large lateral external oblique flap was brought over and sutured to the pubic tubercule and to the medial cut edge of the rectus sheath to reinforce the weakened area. It was possible to approximate these structures without tension for a little over half the length of the rectus defect. The under surface of the medial external oblique aponeurosis was then sutured over the lateral in an imbricating fashion, this imbrication being carried three to four cm proximal to the repaired ventral hernia defect. The free edge of the medial external oblique was then tacked to the exposed lateral leaf, across the distal suture line, and on up for the length of the fascial incision.

This method of repair placed three aponeurotic layers over the hernia defect and the congenitally weak inguinal floor.

Postoperatively the patient had an uncomplicated course and was able to resume his duties within three weeks.

DISCUSSION

The congenital inguinal defect demonstrated in this patient can be found well described in an excellent presentation of surgical anatomy of the inguinal region by Anson, Morgan, and McVay.[1] These authors noted, in their dissections of 500 body halves of internal oblique and transversus abdominal layers, that five in 58 body halves lacked muscle, aponeurosis, or thickened fascia in the inguinal triangle caudal to the lower margin of the internal oblique muscle. Their findings should be familiar to any surgeon undertaking inguinal herniorrhaphy.

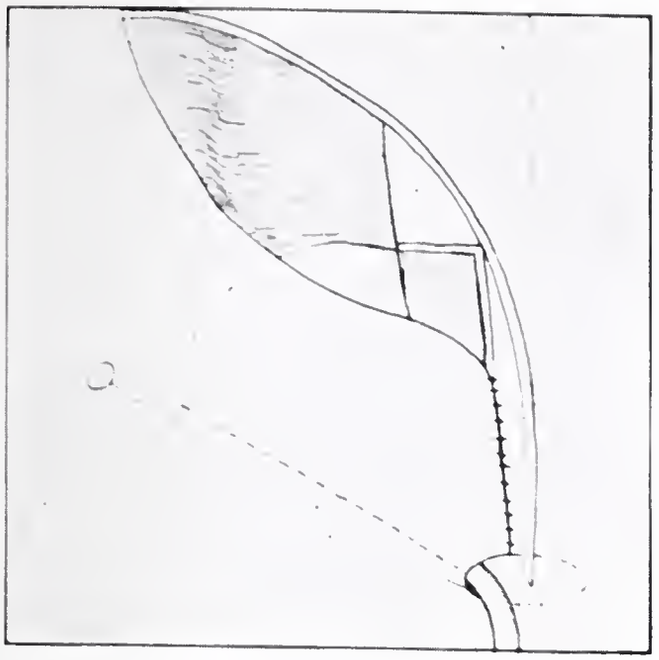


FIG. 4.—*This demonstrates the lateral external oblique flap sutured to the cut edge of the rectus sheath and rectus flap.*

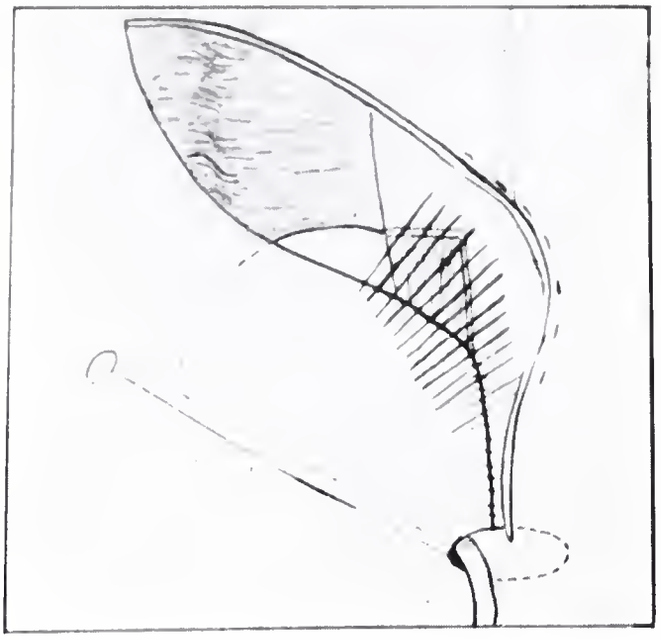


FIG. 5.—*Completion of the repair by imbrication of the medial leaf of the external oblique fascia to the lateral is shown.*

The Spigelian hernia appeared to occur through a cleft of congenital organ in the internal oblique and transversus structures. No vessels occurred in the neck or on the surface of the hernia sac. The size of the hernia indicated a probable longer existence than credited by the patient's history.

SUMMARY

1. A Spigelian hernia was found in conjunction with a congenital deficiency of the normal musculoaponeurotic components of the inguinal floor.

2. The etiology of this hernia conforms to the theory of a congenital defect of the internal oblique and transversus abdominal layers.

3. A method of inguinal floor repair is presented, which was described by Berger[3] in 1902 in the first reported use of a flap of rectus sheath for inguinal herniorrhaphy. It is felt that this method has a broader application in the surgery of inguinal hernia than heretofore utilized. ■

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The periodic Asian or Caribbean filariasis may be transmissible in Hawaii. The Samoan kind is not.

Is Filariasis Being Transmitted in Hawaii?

ROBERT M. WORTH, M.D., Ph.D.,* *Honolulu*

• *A survey of 261 elementary school children in Laie, where there are Culex quinquefasciatus mosquitoes and where for at least ten years there have been significant numbers of Samoan immigrants infected with nonperiodic strains of Wuchereria bancrofti, revealed no microfilariae among 186 non-Samoan children or among 20 Hawaiian-born Samoan children, but among 55 Samoan-born children there were three with microfilariae in their peripheral blood.*

OF THE four species of mosquitoes present in Hawaii, the highly prevalent night-biting Culex quinquefasciatus is a well-known and efficient vector of periodic strains of Wuchereria bancrofti filariasis in Asia and in the Caribbean area. There is some controversy, however, as to whether this mosquito is able to transmit the nonperiodic filariasis found in Samoa, Tahiti, and other South Pacific islands.

Hu,[1] using Samoan cases of nonperiodic filariasis to feed Hawaiian C. quinquefasciatus mosquitoes, stated that these mosquitoes were able to serve as a vector, but he gave no details of his experiment. Rosen[2] came to the opposite conclusion after extensive work in the Tahiti area.

During the past ten years, an increasing influx of Samoans to Oahu has brought our current Samoan population to about three or four thousand, of whom an estimated 15% to 30% have blood smears positive for the microfilariae of nonperiodic W. bancrofti.[3, 4] Although no cases of filariasis in native residents of Oahu have been reported to the Department of Health, it was decided to make an attempt to discover indigenous cases of filariasis in a setting where there is maximum potential risk of transmission of filariasis, as a test of the vector efficiency of our local mosquitoes.

METHOD

The largest single concentration of Samoans along the swampy, Culex-infested windward coast of Oahu is at Laie, where there has been a considerable settlement of Samoans for the past ten years. They now number about 500 to 600, with a fairly high rate of travel back and forth to Samoa.[5]

A casual sample of 112 adult Samoans in Laie (two thick smears of peripheral blood taken after church one Sunday in June, 1963) showed 17 (15%) positive for microfilariae.[4] The data presented below showed a five per cent positive rate among elementary school children from Samoa who are now resident in Laie.

With a mixed population of about 500 Samoan adults and children in Laie, it would therefore seem reasonable to estimate that there is an overall microfilaria-positive rate of about ten per cent among them, numbering approximately 50 persons. Jachowski, Otto, and Wharton[6] have demonstrated that in the absence of reinfection, Samoan strains of W. bancrofti can continue to produce microfilariae for several years (i.e., microfilariae may be found in the peripheral blood of

* Professor of Public Health, University of Hawaii.

This work was done while the author was working parttime in the Communicable Disease Division of the Hawaii State Department of Health, and he wishes to acknowledge the assistance of its Executive Officer, Dr. Ira B. Hirschy, as well as that of the Department of Education, Miss Ruth Worth, Dr. Richard Arnold, Mr. Pat Aiu, and Miss Carol Ching.

(Report number 002 from the Pacific Biomedical Research Center.)

Received for publication December 9, 1963.

Samoans who have been away from Samoa for several years).

The following reasonable assumptions are therefore made as a basis for this test.

(1) For the past ten years there have been some 50 microfilaria-positive Samoans living in Laie.
(2) During the same period of time there have been approximately 1,200 non-Samoans living in the same community, and of these approximately 300 are elementary-school children.[7]
(3) At the same period of time there has been a continuous prevalence of C. quinquefasciatus in the community, with breeding found in nearby drainage ditches and swampy pasture areas.[8]

The elements necessary for transmission of W. bancrofti from the infected Samoans to the non-Samoan members of this small community would therefore seem to have existed for the past ten years, yet during this whole period of time no case of filariasis has been reported in a non-Samoan. To test the possibility that the absence of cases has been due to a failure of reporting or a failure of diagnosis, it was decided to do a microfilaria survey among the 450 children at Laie elementary school. Notes were sent home with the children to request parental permission to examine each child, and Table 1 shows the response.

TABLE 1.—*Microfilaria Survey at Laie Elementary School. Percentage of Children Cooperating.*

	NON-SAMOAN CHILDREN	SAMOAN CHILDREN
Number Enrolled in School	308	142
Number Examined	186	75
Percentage Cooperating	60%	53%

Of the 75 Samoan children cooperating, 20 were born and raised in Hawaii, while 55 were born in Samoa and had come to Laie during the past ten years. The survey was made at the Laie School between 10-12 A.M. on September 5, 1963. Each of the 261 cooperating children had two standard thick smears made on a single glass microscope slide. These smears were allowed to dry overnight at room temperature, then placed in a 37° C. incubator for 30 minutes for final drying before being laked and stained with dilute aqueous Giemsa. The smears were then examined under low power microscopy by the author and an experienced laboratory technician who has spent 30 years working in areas where filariasis is present. The slides were numbered in a random fashion so that the examiners were unaware whether any slide was from a Samoan or non-Samoan.

RESULTS

Of the three Samoan children with microfilariae, each averaged only one microfilaria per thick smear. One of these children had come from Samoa only four months ago, one two years ago, and one three years ago. They were 12, 9, and 10 years of age, respectively.

TABLE 2.—*Microfilaria Survey at Laie Elementary Schools. Percentage of Children with Microfilariae.*

	NON-SAMOAN CHILDREN	SAMOANS BORN IN HAWAII	SAMOANS BORN IN SAMOA
Number Examined	186	20	55
Number with Microfilariae	0	0	3
Percentage with Microfilariae	0%	0%	5%

DISCUSSION

The results of this survey certainly support Rosen's estimate of the poor vector ability of C. quinquefasciatus in transmission of the nonperiodic strains of W. bancrofti found in the South Pacific. The continuing influx of filaria-infected Samoans to Hawaii evidently does not pose a threat to public health in Hawaii.

Culex quinquefasciatus is, however, well known as a very efficient and important vector of the *periodic* strains of W. bancrofti found in Asia and the Caribbean area. Therefore, it is imperative that all cases found be reported to the Health Department at once for investigation of a possible Asian or Caribbean source.

SUMMARY

This supports Rosen's conclusion that C. quinquefasciatus is not an efficient vector of Polynesian strains of nonperiodic W. bancrofti, and strengthens the belief that the immigration of Samoans and Tahitians does not pose a filariasis threat to Hawaii.

Asian and Caribbean strains of W. bancrofti remain a potential threat, however; so filariasis cases should be reported to the Health Department at once for source investigation. ■

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Falling backward off a stool saved this man's life!

Early Hypernephroma Revealed by Trauma

FREDERICK B. WARSHAUER, M.D., and
J. I. FREDERICK REPPUN, M.D., *Honolulu*

• *An asymptomatic hypernephroma was discovered because of hemorrhage into it following a fall. The patient is still free of evidence of disease four years after surgical removal of the tumor.*

MALIGNANT tumors of the kidney usually manifest themselves by intermittent hematuria, a palpable mass, weight loss, fever, and other cardinal signs of advanced neoplastic disease. Occasionally, intravenous urography reveals an unsuspected neoplasm during radiologic surveys for other conditions. Rarely, the accidental discovery of an early lesion is made when nephrectomy is performed for benign disease.

The following case report is of interest, since trauma played the key role in the discovery of an asymptomatic hypernephroma.

CASE REPORT

A 64-year-old Caucasian watchman was admitted to St. Francis Hospital on April 22, 1960, with the chief complaint of pain in the left flank and lower posterior chest since 13 days previously, when he had fallen off a stool backwards, striking his left posterior chest area.

He had been seen at home by his physician two days after the fall because of pain in this area. Physical examination at that time was not remarkable except for local tenderness over the left tenth rib posteriorly, aggravated by deep breathing and coughing. A clinical diagnosis of probable rib fracture was made, and the lower chest was strapped.

Two days later he was again seen because of abdominal cramps and constipation. At this time, it was noted that the abdomen was somewhat distended. Hospitalization was advised, but the patient refused. An enema was prescribed, but he took castor oil instead.

He continued working, and was not seen again until one week later, at which time he was still having pain in the left flank and left upper quadrant. Physical examination at that time revealed a large, tender mass in the left upper quadrant of the abdomen and left flank. The borders of the mass were rather well defined, and it was noted to move with respiration.

The patient finally agreed to be hospitalized,

Received for publication February 12, 1964.

and an intravenous urogram was performed the following day. Portions of the report state: "A preliminary film of the abdomen and subsequent films show a well-defined large soft-tissue density in the left lower abdomen measuring about 14 cm in diameter. This is continuous with the lower pole of the left kidney, the outline of which is not definitely identified, so that it is likely that this is attached to and arising from the kidney. There is a fracture of the lateral portion of the left tenth rib." An electroeardiogram was normal.

On April 25, 1960, under endotracheal anesthesia, the abdomen was entered through a long left paramedian incision. A huge retroperitoneal cystic tumor was palpably attached to the lower pole of the left kidney. The kidney and cyst were mobile and there was no gross evidence of metastatic malignancy. Inspection of the liver, spleen, gall bladder, stomach, duodenum, small intestine, and colon revealed no further abnormalities. The appendix was fibrotic.

The intestines were retracted to the right, and a long incision was made in the lateral peritoneal fold adjacent to the descending colon. The colon was reflected medially and the cyst exposed. By blunt and sharp dissection, the cyst was freed from the surrounding fascial attachments and its connection with the lower pole of the kidney demonstrated. A rubber-shod clamp was placed across the lower pole of the kidney and the renal cortex incised in this area. The cyst was removed from the field and delivered to the pathologist for examination. He reported, on frozen section, "Hematoma into a simple or solitary renal cyst."

Two or three small vessels in the kidney substance were individually ligated. The lower pole of the kidney was closed with interrupted sutures of #0 chromic gut tied over small bits of gelfoam. This closure was further reinforced by suturing surrounding bits of perirenal fat and Gerota's fascia. A large Penrose drain was introduced through a stab wound in the left flank and anchored by a suture to the vicinity of the lower pole of the kidney. The colon was replaced and the lateral peritoneum tacked with a few interrupted sutures of fine silk. The abdomen was closed in layers. Immediate postoperative condition of the patient was satisfactory.

PATHOLOGIC REPORT

The final pathological report by Dr. Raid Chappell follows:

"The specimen is an encapsulated ovoid tumor 14 cm in diameter. External surface is smooth, with an encapsulated appearance. It has adherent to it a small amount of normal-appearing fat, and one piece of unremarkable kidney parenchyma 2.2 cm in greatest diameter. On sectioning, it is seen to be a cyst whose wall is tough and leathery, averages 1.4 cm in thickness and has in it occasional calcified zones. The cyst contains 480 gm of clumped, chocolate-like degenerated blood, some of which is markedly adherent to the inner surface." *Microscopic:* "A large number of paraffin sections demonstrate a thin rim of hypernephroma tissue lining the internal aspect of the cyst. This layer of viable neoplastic tissue is scarcely one or two mm wide and in places even thinner. Cytologically, there is no evidence of anaplasia or malignancy and mitotic figures are rare if not entirely absent. Accordingly, the diagnosis of adenocarcinoma of the kidney or hypernephroma is made in this case, strictly on the gross size of the cystic neoplasm, plus the fact that benign tumors of the kidney comprise less than five per cent of the new growths of that organ. Structurally, this tumor is composed of tubular, papillary, and clear cell elements. Of course, there is extensive old and recent hemorrhage with large amounts of cholesterol present. Incidentally, the presence of cholesterol is further evidence of benignancy since that chemical is usually a feature of adenomas and not renal carcinomas. The neoplasm questionably or sluggishly invades its thick fibrous capsule at one or two microscopic-sized points. Outside the capsule and in the adjacent renal parenchyma are several satellite nodules of papillary, tubular, and acidophilic adenoma. These satellite adenomas, thick fibrous capsule, the presence of abundant cholesterol, the lack of cellular anaplasia, are all strong points indicating origin from a preexisting adenoma."

The postoperative course was marred by an unexplained diarrhea, which eventually responded to symptomatic therapy. A stab wound infection around the drain was treated with irrigations and later with Ilosone, Chloromycetin, and Gantrisin. *Staphylococcus aureus* coagulase positive, phage type 80/81, was cultured from the pus. The patient was discharged on the 20th postoperative day. He was seen on June 29, 1960, at which time he had gained seven pounds and felt fine, except for occasional slight pain in the operative site. He returned to work on July 1, 1960.

SUMMARY AND DISCUSSION

The advisability of radical nephrectomy was discussed following the final pathological report, but was discarded because of the patient's age, and the low-grade malignancy of the tumor. It was felt that an adequate margin of normal kidney had been removed, and that any recurrence would probably be the result of vascular emboli rather than local invasion.

He has now survived four years with no evidence of disease. ■

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The President's Page



At a recent Council meeting there was a discussion of what might appropriately be written on the President's Page. One Councillor suggested that a Biblical text might be in order. The Bible, a distillate of ancient knowledge, can be referred to today for advice, for its wisdom is timeless. For this month's text, therefore, we will quote from Matthew V, verses 15 and 16:

> Neither do men light a candle, and put it under a bushel, but on a candlestick. . . .
> Let your light so shine before men, that they may see your good works. . . .

Individually, the doctor's image is good. He often is considered wonderful by his patients. His medical skills are well recognized, as are his contributions as a community leader in youth work, churches, service clubs, voluntary health agencies, political organizations, and in many other aspects of community life.

Collectively, however, the physicians' image is often bad. The other man's doctor is supposed to be against everything, with his head deep in the sand. He is said to be concerned solely with promoting his own interests, and is supposed to have gun-barrel vision limited to quick looks at his patients, the cash register, the Cadillacs in the garage, and the golf course.

This isn't true. The image of a physician, both collectively and individually, should be good and it will be, if we let our light shine before the world.

I am happy to help put our light before the world. We are proud, not ashamed, to be physicians and part of organized medicine.

Our medical association in Hawaii now is 109 years old. Hawaii has perhaps one of the best public health pictures of any state in America and this could only have been accomplished by very close cooperation between organized medicine and government health agencies. Our light shines brightly in this area.

Organized medicine in Hawaii has about a dozen committees concerned solely with public health. We have put on regular diabetes detection drives and have supported and engaged in mass immunizations for poliomyelitis. Nearly nine-tenths of the babies and youth of Hawaii have been given Types I and II Sabin oral polio vaccine against this one-time scourge. We cooperate with registries of tumors and mental illness, and our organization has been officially designated by the State to study and evaluate the deaths of infants and mothers. This collective action in public health has helped to give Hawaii one of the best public health records in the world.

Organized medicine has responded to great disasters, such as that at Pearl Harbor in December, 1941, and smaller disasters such as the recent plane crash in Hilo. It is prepared to aid in all emergencies that arise. Our charities have been not

only private, but collective and massive. A survey some years ago showed that physicians give away about a fifth of their time in charity work, in educational enterprises, and in community services. In the State's indigent care programs, the taxpayer would be far more burdened were it not for the full support of physicians who give generously of their time without recompense.

We have been very active in health education, both for the general public and for interns, residents, and student nurses. The recent Careers Day program was an outstanding event in which some 70 physicians gave a half day each to escorting high school youth around the medical community. In the past two years over 150 physicians have taken part on our "Call the Doctor" television shows, and perhaps a hundred have taken part in our weekly educational radio program. Weekly educational press releases go to all the newspapers of the community. More than one million educational leaflets have been distributed to the public within the last year.

Physicians are actively providing training for interns and residents, nurses and other paramedical personnel. The State pays to educate teachers, engineers, and mechanics, but a great deal of the cost of medical and nursing education in Hawaii is met by physicians giving of their own free time.

We have also been concerned with people beyond our borders and have dispatched physicians to Pacific islands on emergencies great and small. Our Operation Kokua Samoa resulted from an emergency need expressed by the Governor of Samoa when that American possession lacked medical personnel. During a period of two years, no less than 20 physicians from Hawaii gave up their vacations to work for periods of several weeks without pay to make better the lot of our Samoan cousins to the South. This humanitarian enterprise may be on the brink of expansion, for our services may be in demand in Western Samoa, and in the islands of the Pacific Trust Territory where the officials know they may call upon us, with assurance of response.

I do not know in detail what other groups do collectively for evaluation of their trades or professions. I do not know what is done by the banker, the butcher, or the proverbial candlestick maker. I do know what organized medicine does, and I rather suspect that we may do more than any other group. At the hospital, county, and state levels there are many evaluation committees such as fee schedules and adjustment committees, and particularly the "grievance" committee. The county societies are concerned with ethics, and as an example the Honolulu County Medical Practice Committee meets nearly every week to investigate complaints against physicians, problems that arise among physicians, problems between hospitals or insurance carriers and physicians, and problems that exist between physicians and their patients. Our self-policing is not perfect, but we work at it, and from my experience, I believe we do a pretty good job.

I think we stack pretty high.

I am proud to be a physician.

I am proud to be a part of organized medicine.

Let us *not* put our candle under a bushel, but let our light shine before the world.

Samuel D. Allison

P.S. Nurture this flame. Don't throw mud on it!

HAWAII MEDICAL JOURNAL

Editorials

Brick and Mortar Planning

It's summer—and open season once again for prospective sponsors to hunt on the Hill-Burton preserves. In looking back upon the annual June meeting of the State Advisory Commission on Hospital and Medical Facilities, Dr. Leo Bernstein has paraphrased Shakespeare by reflecting that "Brick and Mortar are such stuff as dreams are made on."

"Brick and Mortar Planning" was cited in an article by Karl S. Klicka, M.D., Executive Director, Appalachian Regional Hospitals, Lexington, Kentucky, "as the limit of present efforts, in contrast to the hoped for streamlined planning for a more effective hospital system in our community." Yet it is this very "muscle and blood" of day-to-day planning that is being carried on by your Health Department's Hospital and Medical Facilities Branch. To date there has been no new concept presented on area-wide regional planning by the yearling Health Facilities Planning Council.

Be not confused! The functions of the two are as separate and distinct as jam is from jellyfish. The heart, nerve, and sinew efforts of the Hospital and Medical Facilities Branch of the Department of Health show a tally of 41 projects underway or completed that have brought to Hawaii the astronomical sum of $9,697,000 in Federal funds since 1948. Think of it, over $606,062 per year or in excess of $11,655 per week, during all this time. And these are returned tax dollars, many of which Hawaii has contributed! Has ever so worthwhile an effort toward such a desirable goal been accomplished at such a small cost to the State as a $30,273 annual budget?

In the welter of words that has surrounded the development of the Health Facilities Planning Council, consternation has compounded confusion for in the eddy currents, even some professional men have been led to believe that the functions of the Hospital and Medical Facilities Branch of the Department of Health are being or could be taken over by the Council—a pilot project committed to three years of life unless the State takes over the $219,000 to $259,000 three-year tab it will take for it to survive at the end of the Federal support.

Such is not possible, however. In a recent communication from the Acting Program Director of the Hospital and Medical Facilities Division of the Region IX Office, U. S. Public Health Service, it was clearly stated that:

> [inquiry was made] whether the Health Facilities Planning Council, which is a private nonprofit organization, can be designated the advisory council for the hospital construction program and whether the council could be authorized to administer the program. We have some doubt that the designation of some private nonprofit organization as the "Health Facilities Planning Council" would be consistent with the Federal law. Even if it would be acceptable, however, the State, having no control over the membership of the nonprofit organization, could not assure the representation on the council required by the Federal law, so that the designation of the nonprofit organization as the advisory council would be imprudent as a practical matter. Further, any designation of the Hospital Facilities Planning Council in this capacity would be in contradiction to the philosophy and purpose for which these councils were established. If such were done, a determination would have to be made to ascertain if the council was eligible for further grant funds under the conditions of the original application.
>
> Turning to the second part of the question, we do not see how the Health Facilities Planning Council could be authorized to take over the hospital construction program without an amendment to RLH 1955, Section 48A-3. Even then, we would question whether the State Legislature could constitutionally delegate administrative authority to a private nonprofit organization.

It has been established by State Law that the Department of Health is the designated State agency to administer the provisions of the Hill-Burton law, and that, for reasons including conflict of interest, they cannot be administered by any private nonprofit group.

Whatever the future course of the Hill-Burton law and appropriations, in this time of great controversy, it is for the medical profession to present a unified consensus out of whatever internal fractious groups may exist, in order that, having determined the best course, we may move forward with neatness and dispatch.

WILBUR S. LUMMIS, JR., M.D.

Nursing–Then and Now

We are all aware of the progress being made in nursing education and of the changing role of the nurse in the hospital. The following point up just how much change there has been from the "good" old days. The 1887 job description was made available to the JOURNAL from the National League for Nursing's Historical Source Material Committee, the 1964 description applies locally and was prepared by the Hawaii League for Nursing.

HOSPITAL STAFF NURSE, 1887

1. Daily sweep and mop floors of ward, dust patients' furniture and window sills.
2. Maintain an even temperature in your ward by bringing in a scuttle of coal for the day's business.
3. Light is important to observe the patients' condition. Each day fill kerosene lamps, clean chimneys and trim wicks. Wash windows one day each week.
4. Nurses' notes are important in aiding the physicians' work. Make your pens carefully—you may whittle nibs to your individual tastes.
5. Each nurse on day duty will report at 7:00 A.M. and leave at 8:00 P.M. except on the Sabbath on which day she will be off from noon to 2:00 P.M.
6. Graduate nurses in good standing with the director of nurses will be given an evening off each week for courting purposes, or two evenings a week if she goes regularly to church.
7. Each nurse should lay aside from each day a goodly sum of her earnings. If you earn $30.00 a month, you should set aside $15.00 a month so that you will not become a burden in your declining years.
8. Any nurse who smokes, uses liquor in any form, gets her hair done, or frequents dance halls will give the director of nurses good reason to suspect her worth, intentions, and integrity.
9. The nurse who performs her labors, serves her patients and doctors faithfully and without fault for five years, will be given an increase of five cents a day providing there are no hospital debts that are outstanding.

—and takes care of 50 patients.

HOSPITAL STAFF NURSE, 1964

1. A hospital staff nurse renders nursing care and related assistance to hospital patients and assists with the supervision of auxiliary personnel.
2. She supervises the functioning of special equipment such as suction machines, oxygen tents, resuscitators, positive pressure valves, and respirators.
3. She administers medications and keeps an accurate narcotic count and assists with the administration of intravenous medications.
4. She maintains neat, accurate, and concise records of patient care.
5. She directs the functioning of teamwork in patient care.
6. She must have the ability to recognize and interpret symptoms, and to report accurately on a patient's condition, and assist with or institute remedial measures for adverse developments.
7. She makes the rounds with physicians to patients in her area and assists as necessary.
8. She is expected to keep pace with new trends and developments in the field of nursing.
9. She works 40 hours a week and is paid extra for evening or night duty and overtime. Her salary begins from $365.00 to $370.00 a month, with annual increments.

—and takes care of an average of five patients.

Erratum atque Apologium

We regret that no acknowledgment was made, purely through oversight, of the financial assistance given by the Straub Medical Research Institute of Hawaii to make possible the publication of Dr. William Bachrach's article in our May-June issue. The error was not Dr. Bachrach's, but ours.

The Straub Institute, as pointed out by Dr. Grant Stemmermann in an editorial a year ago, was founded by the Straub Clinic but is not controlled by it. A majority of both the members and the directors are drawn from outside that organization. The purposes of the Institute are the promotion and support of medical research and medical education. The overwhelming bulk of its gifts to date have been to other institutions or doctors outside Straub Clinic.

HAWAII MEDICAL JOURNAL

This Is What's New!

• **Plasma chloride** level may be more important than **plasma phosphate** for differentiating **hyperparathyroidism** from other causes of **hypercalcemia.** Of 33 patients with proven primary hyperparathyroidism, all had plasma chloride levels of not less than 102 mEq per liter. A single exception had been vomiting profusely. In a similar group with hypercalcemia due to causes other than hyperparathyroidism, all had plasma chloride levels of not more than 102 mEq per liter. Here also one exception was a patient who had a level of 103 mEq per liter. (*Brit. Med. J.* [May 2] 1964.)

• All is now well with the formerly **rachitic infants** of Dundee. With heavy **vitamin D fortification** of the Dundee infants' diets starting in the 1930's, rickets all but disappeared; however, infantile hypercalcemia and vitamin D resistant rickets soon began to appear in increasing numbers. Cases with idiopathic hypercalcemia responded to **reduction** in excessive amounts of **vitamin D** in the diet. (*Lancet* [Mar. 28] 1964.)

• Rupture of the aorta is being observed with increasing frequency because of faster speeds on the highways. Of 68 patients with **traumatic rupture of the aorta,** 59 were involved in **traffic accidents.** Rapid decelerative forces with resulting rise of intravascular pressure is a chief factor in rupture of the aortic isthmus. **Atherosclerosis** was not unusually marked in patients experiencing rupture of the aorta. Prophylaxis is the only practical answer to the problem. (*Nord. Med.* [Mar. 12] 1964.)

• A senior medical student at Johns Hopkins University and an emeritus professor of **psychobiology** at the same institution teamed up to describe the detection of **lung cancer** by electrical skin resistance. An unusually high proportion of abnormal patterns in **skin resistance** in patients having lung cancer was discovered. These abnormalities were attributed to lesions involving the sympathetic ganglia in the cervical lumbothoracic regions. (*Arch. Int. Med.* [May] 1964.)

• The treatment of **cerebral infarction** by removal of the extracranial thrombosis, such as in the carotid artery, may convert the infarction to a **massive hemorrhage.** The California authors suggest that this is precisely what happened in five cases operated upon, and urge caution in the performance of surgical procedures in such patients. (*J. Neurosurgery* [Mar.] 1964.)

• Baboons, like humans, have **serum cholesterols** that vary from one baboon to the other. Although not mentioned in the report, the major difference between **baboons** and **humans** was the fact that no baboon asked what his cholesterol was. (*Circulation Research* [Apr.] 1964.)

• The trend in hospitals and medical offices to "use it up and throw it away" continues. The **disposable** IV bottles and tubings, syringes, and needles have become acceptable in all modern hospitals. Now a San Francisco ophthalmologist has designed an **eight-day eye tray** which remains at the patient's bedside complete with eye pads, tape, sterile eye drops, scissors, irrigating solutions, and cotton balls. The cost per dressing with the disposable tray is about the same as those prepared in the Central Supply Room. Sooner or later someone is going to hit the jackpot and design a practical, **disposable bedpan.** (*Arch. Ophthalmology* [May] 1964.)

• The **thymus,** which had been relatively dormant in medical writings since the pediatricians gave up **irradiation** for status **thymicolymphaticus,** is being linked with many diseases and syndromes. A Middlesex physician reports that **Henoch-Schonlein purpura** with hyperglobulinemia and other hematological abnormalities was secondary to a benign thymoma. Excision of the thymoma resulted in the disappearance of the purpura. (*Lancet* [Mar. 28] 1964.)

• Dextro-amphetamine causes diuresis in patients with idiopathic edema and increased sodium excretion in normal subjects as well as patients with idiopathic edema. The investigator describing this suggests that a **decrease in aldosterone secretion** is responsible for **natruresis** induced by dextroamphetamine. (*Metabolism* [May] 1964.)

• Of over 1,000 employed men who experienced their first **heart attack,** 30 per cent **died** within 30 days of the attack. Of those that survived this period of time, 74 per cent went on to **survive** five years. Approximately one half, or 46 per cent, who recovered were still employed five years later. (*New Eng. J. Med.* [Apr. 30] 1964.)

• **Disseminated melanomatosis** was treated with repeated injections of **vaccinia (cowpox) virus.** After a year of such treatment, the cutaneous and visceral tumors disappeared. (*Cancer* [June] 1964.) ■

F. I. GILBERT, JR., M.D.

Hawaii Academy of General Practice

There is no phrase in medical economics more trite than "free choice of physician." The license with which it is bandied about, even by the high and mighty, in our profession permits no argument; it is medical gospel. The phrase, itself, has not even been challenged by proponents of medical insurance plans that preclude the principle implied, i.e. closed panel medical care.

CLOSED PANEL MEDICAL CARE

Closed panel medical care plans are all about us. The advent of retirement homes is just one more example of the inroad into the free and open enterprise that was the private practice of medicine. Plantations, HMSA, Kaiser, Medicare, VA, DSS, USPHS, the military, to name a few, all utilize closed panel systems to a greater or lesser degree. Since there are probably very few of us practitioners who are completely "pure," i.e. who have not compromised our so-called principles to this slight extent, why then the vociferous morality about the lack of "free choice" under King-Anderson or its ilk? Are we, in fact, so white that we can throw brickbats at the National Medical Service in England, blackened by the stigma of socialization?

WHAT IS "FREEDOM OF CHOICE"?

How free is a layman, under our present system of private medical care, in choosing a physician? The freedom of his choice is belittled by his lack of knowledge of the criteria necessary to make a good choice. He could, but he almost never does look up the curriculum vitae of a physician. He can walk into your office or mine and look at the walls for diplomata and certificates, but he almost never walks out on the basis of dissatisfaction with what he reads thereon. He may be referred by another physician, in which case his trust is in his original doctor, not our problem here.

He is more likely to have had the word from a friend of your patient or mine, a person "sold" on us—whether we be eminent scientists or ignorant but successful, and, I should hope, harmless charlatans who practice the art of medicine. What sort of criteria does this patient have, this poor, deluded, and hoodwinked individual who trusts you and me to cut him up or to half poison him with "wonder" drugs?

FREEDOM TO UN-CHOOSE

The answer to all this, of course, is that we support freedom of *intelligent* choice of physician. In fact, what we really promote is the freedom to refuse, rather than to choose; freedom to un-choose, to break off the intimate physician-patient relationship on the part of either patient or physician. If the panel of physicians is big enough, a measure of this freedom comes into the picture. It becomes apparent, then, that what we and the AMA deplore is not panel medicine per se but the degree of restriction of choice within it. It behooves us to so state the case. The discerning and intelligent layman resents the cliché, "free choice of physician," thrown at him constantly.

MEDICAL TRAINING

There is another aspect to this that lies hidden because of the flash impact of the cliché.

If the medical profession in modern times were as disparate in the training and capabilities of its membership as it used to be in the days of the diploma mill and the Class C medical school, the matter of choice by the layman as to whose shingle to walk under might well be serious and hazardous.

We pride ourselves on our excellence as a profession; we have imposed standards upon ourselves such that it should become next to impossible to hatch out a physician not properly trained. So why the furor over "free choice," when there are only top quality physicians to choose from?

Herein lies our greatest weakness in combating the encroachment of socialized medicine—and it is all our own doing. The same layman who enters the portals of a large private medical clinic, perfectly willing to have the receptionist choose for him the physician for his case because he is putting his trust in the reputation of the clinic as a whole, will go for socialized medicine, because he has been conditioned to put his trust in the entire medical profession. There are a great many such patients in our country, people who could care less who the doctor is provided he, the patient, is cared for, and at reasonable cost.

LUXURY MEDICINE?

"Free choice" medicine is luxurious, high class,

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HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii

This is the fiftieth installment of In Memoriam —Doctors of Hawaii.

Unpei Shimamoto

Unpei Shimamoto was born on February 5, 1879, in Marifu-Mura, Kuga-gun, Yamaguchi Prefecture, Japan.

He received his medical degree from Tokyo Imperial Medical College in 1904.

On February 1, 1914, he arrived in Honolulu. After having passed his Territorial Medical Board examinations, Dr. Shimamoto began his practice in Honolulu. In 1920 he moved to Hawaii and was for a time in charge of the Shimamoto Hospital in Hilo. About 1925 he located at Kapaau, Hawaii, and by 1928 he had returned to Honolulu and was in practice.

Dr. Shimamoto and his wife, Shige, were the parents of two sons.

On November 16, 1938, Dr. Shimamoto died in Honolulu at the age of 59.

James Albert Morgan

James Albert Morgan was born August 16, 1877, at Newton Highlands, Massachusetts, the son of Charles Hardy and Eunice (Davis) Morgan.



DR. MORGAN

He was a descendant of Robert Norman Morgan of Glenmorganshire, Wales, who settled at Salem, Massachusetts, in 1635. On his maternal side he was a descendant of William Brewster, who came to Plymouth in 1920.

He was educated at the Little Blue School, Farmington, Maine; Allen's English and Classical School, West Newton, Massachusetts; Cambridge Latin School, Cambridge, Massachusetts; and Exeter Academy.

War with Spain brought his enrollment in the First Regiment of Heavy Artillery Massachusetts Volunteer Militia. When the Cuban campaign ended, he enrolled in the Army Hospital Corps and was sent to the Philippine Islands by way of the Suez Canal, on the hospital ship "Missouri." With troops chasing Aguinaldo through the jungles he gained his most adventurous and valuable experiences.

When peace was declared he entered the Civil Service and remained in the Philippines, where he studied Spanish and the island dialects. He made one trip to his home in Cambridge and spent vacations in China and Japan where he made lifelong friendships.

Returning to Philadelphia in 1905, he entered Temple University and was granted his M.D. degree in 1910. Dr. Morgan was a resident at "Blockley," Philadelphia General Hospital, from 1910-1911.

In 1912 he was Assistant Visiting Ophthalmologist at the same institution and Assistant Ophthalmologist at Philadelphia Polyclinic. He also served as assistant in ear, nose and throat at Old Pennsylvania and Jefferson hospitals from 1912-1913. During the same period he was engaged in general practice.

At Media, Pennsylvania, on December 20, 1911, Dr. Morgan married Elsie Edna Johnson. There were three sons born to the Morgans: James Albert, William Brewster, and Andrew Lane.

In June, 1913, Dr. Morgan came to Honolulu and specialized in ophthalmology and otolaryngology. During the following years he served as visting ophthalmologist and otolaryngologist at The Queen's Hospital, St. Francis Hospital, Children's Hospital, Mid-Pacific Institute, Castle Home, Lunalilo Home, Shriners' Hospital, Palama Settlement, and the California Packing Corporation. He was also consulting ophthalmologist and otolaryngologist to the U. S. Public Health Service and to the Bureau of Crippled Children of the Board of Health, Territory of Hawaii.

From 1911 to 1915 Dr. Morgan was first lieutenant in the Medical Reserve Corps of the U. S. Army, resigning to accept a commission in the U. S. Naval Reserve. During World War I he served as a member of the Medical Advisory Board of the Selective Service System, serving as ophthalmologist and otolaryngologist at the Naval Dispensary until called into active service in the same capacity at Naval Hospital, Mare Island, California.

Dr. Morgan held certificates in postgraduate work.

He contributed to numerous medical journals during his professional career, among the most important being the *American Journal of Ophthal-*

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Bureau of Medical Economics

A few weeks ago we concluded a four-day seminar for medical assistants at the Mabel Smyth Auditorium. As the organizer and one of the speakers, I had more than the usual opportunity to talk with over 275 medical assistants.

Some surprising facts came to light about you, the doctor and employer. Naturally, most of my conversations were about credit and collection. When the girls started to air their various complaints, I realized that a spot of "air clearing" should be the order of the day, especially in the matter of collections.

What does your assistant look to you for?

A Collection Policy: That is, definite instructions as to when an account is to be turned over to a collection agency. Don't use the old expression "use your own judgment." Most assistants prefer to know what you, as the employer, wish to do about your money. There should be a hard and fast rule as to precisely when accounts should be turned over.

Any account that has shown no reason for nonpayment nor financial return to billing after three months is, in my humble opinion, ready for the collection agency.

Specific Instructions on Partial Payments: Often medical assistants tell us that their doctors have indefinite policies regarding partial payments. Review your delinquent accounts regularly, and leave specific instructions as to precisely how much per week or month your assistant should accept until an account is paid in full. Indecision in such cases puts your staff at a disadvantage. Many experienced delinquents will be quick to note this and use it to their own ends.

Uniform Behavior: A certain type of doctor will tell his assistant to ask for payment, and then will allow the delinquent "time," telling him, "It is quite all right. Do not worry about the account." This is unfair to your assistant. Many medical men "go soft" when faced by the delinquent. This practice puts your assistant in an unfortunate position, one that you alone are responsible for. Back up any instructions you give to your assistant. Her actions should always mirror your thoughts, and she should appear to your patients as a counterpart of yourself. Remember that an assistant who *knows* she is following instructions is always a confident assistant.

Up-to-Date Information: Acquaint your assistant with any arrangements you make on accounts. Keep her in the picture at all times. Never let the poor girl guess what is going on. Many assistants tell me that patients who are behind with their accounts often come to the office, when the doctor is out, and make certain claims. The poor assistant knows nothing about the situation. She hesitates to question the patient's honesty, and therefore does not know precisely what to do.

You are a very busy man, Doctor, but you are running a business—a business that doesn't finish when you have shut your office door on a patient. The rest of your staff must know what is going on. This is essential to the smooth operation of your organization.

A Firm Policy: One of the most common complaints is that many doctors have a habit of changing their collection policies as they would their shirts. Assistants tell us that one week they are told one thing, and the very next week there is a completely new set of instructions. The following week the doctor has another brainstorm and sets up another new set of rules regarding billing and accounts. Doctors, these girls you employ are more than usually interested in their work. They wish to help you. Help them to help you. Study your office systems, select the best one for your organization, then stick to it. Don't alter your existing system just because Mrs. Brown objects to your method of billing or John Doe tells you that he doesn't like to be asked when an account is going to be settled. You will never please everybody, and so don't try. A system with which your staff is acquainted and which is proven will always work smoothly. We at the Bureau of Medical Economics have been investigating new systems for the past nine months, but we never experiment at the expense of our staff. To do this is to throw an office completely out of gear.

If you think that a new system is needed, never be haphazard. You are a doctor, not a systems expert. One would not expect a major office-organizing company to diagnose a hernia. Why, then, try to do an expert's job in a field in which you are not expert?

Above all discuss your collection policy with your medical assistant. She needs to know everything she should about your business, and you are the only one who can tell her. ■

GABRIEL ROGERS
Manager

HAWAII MEDICAL JOURNAL

Infant Death Study

Case 2 of our maternal and perinatal death studies follows:

The mother of this 3 lb. 3¼ oz. male infant was a multigravida in her early 20's. During the 29th week of her pregnancy the patient noted profuse vaginal bleeding without pain. She was admitted to a hospital at 3:50 P.M., less than two hours after the discovery. At the time of admission the bleeding had subsided and only a small amount of blood was seen oozing out of the vagina. Vital signs were within normal limits. Laboratory examination on admission revealed a hematocrit of 40 vol. per cent, hemoglobin of 11.1 gm. per cent, white blood cell count of 11,600 and a differential of 86 segs, 9 lymphocytes, and 5 monocytes. Urinalysis was within normal limits. A consultant was immediately called and the consultant performed a sterile vaginal examination under a double setup. Under examination the cervix was found to be thick and the placenta was palpable at the internal os of the cervix. A diagnosis of marginal placenta previa was made and at approximately 5:30 P.M., two hours following admission, a Cesarean section was performed. At approximately 6:30 P.M., one hour following delivery of the infant, the infant was transferred to a premature nursery at another hospital. The infant expired about 48 hours following delivery of hyaline membrane disease.

CLASSIFICATION

The infant death was classified as being due to obstetrical factors and preventable from a practical standpoint. The factor of preventability was error in judgment by the attending physician and consultant.

CONCLUSIONS AND RECOMMENDATIONS

The committee came to the following conclusions and made the following recommendations:

1. The Cesarean section was not indicated at the time it was performed. The findings of normal blood count and vital signs meant that the patient was in good physical condition and that she had not bled as profusely as she had reported to her physician. Speculum examination under a double setup to determine the source of bleeding was thought to be appropriate, but intracervical digital examination was thought to be ill-advised because of the danger of precipitating massive hemorrhage and forcing an emergency Cesarean section in an obvious case of premature fetus. Because the patient did not bleed in spite of digital examination of the cervical canal, she should have been followed conservatively with bed rest and 4 units of blood, cross-matched and available at a moment's notice.

2. Speculum examination of the vagina and cervix should be done in spite of marked prematurity when placenta previa is suspected, in order to rule out bleeding from other etiology and because the danger of precipitating uterine hemorrhage is not too great.

3. Conservative management should have been followed until the fetus reached viability or as near term pregnancy as possible, with the understanding that immediate evacuation would have been necessary if uncontrollable hemorrhage should have occurred.

4. Radioisotope techniques or soft tissue x-ray films could have been used to localize the placenta if the patient stopped bleeding and if the attending physician felt that it was reasonably safe to send the patient home, with the understanding that readmission would be necessary immediately, should the bleeding recur, and that she should be within easy access to the hospital. If these conditions cannot be met, however, the patient should be kept in the hospital until the fetus reaches viability and the pregnancy then terminated.

5. When the fetus reaches viability and delivery is thought to be obstetrically indicated, then is the time intracervical digital examination under double setup can be done with minimal danger to the fetus. If membrances can be ruptured artificially, it should be done so that delivery vaginally can be accomplished if possible. If central placenta previa is detected or if hemorrhage is the result of digital examination, immediate Cesarean section can be accomplished. ■

MATERNAL AND PERINATAL
MORTALITY STUDY COMMITTEE

HAWAII MEDICAL JOURNAL

Book Reviews

The Pathology of the Pulmonary Vasculature

By C. A. Wagenvoort, M.D., Donald Heath, M.D., Ph.D., M.R.C.P., and Jesse E. Edwards, M.D., 494 pp., $25.50, Charles C. Thomas, 1964.

THIS HANDSOME BOOK of almost 700 photographs contains a lesser volume of text dealing with pathologic pulmonary states that produce the pictured changes in the vessels of the lungs.

It is an atlas and a reference book that lists about all the periodical medical literature of the past fifteen years concerned with the pulmonary vasculature—which is freely quoted, criticized, and reproduced. There is a general tendency to ride the fence in controversial matters rather than to lend strength to any given theory.

A considerable portion is devoted to vessel changes secondary to heart abnormalities and diseases.

The reproductions are excellent and elastic tissue staining is the order. It is recommended to anyone especially interested in chest disease.

PAUL W. GEBAUER, M.D.

★Appraisal of Current Concepts in Anesthesiology. Volume II.

Edited by John Adriani, M.D., 478 pp., $10.75, The C. V. Mosby Company, 1964.

WITH THE RAPID expansion of knowledge in the diverse field of anesthesiology, some method of bridging the hiatus between the current literature of the specialty journals and the often obsolescent writing of the standard anesthesiology textbooks would obviously be of value to the busy clinician. Adriani's book attempts this Herculean task and in the main succeeds quite commendably. The subject matter is well chosen. Clinical applications are stressed and constructive criticism is offered where applicable.

Inevitably, as in any publication with multiple contributors, a certain unevenness of literary style and scientific content is apparent, while an occasional misprint serves to keep the reader alert. However, these are minor criticisms and acquisition of this volume should be mandatory for all anesthesiology residents and most practicing anesthesiologists. It can be read with profit by all physicians who are concerned with the management of the surgical patient.

PHILIP G. JONES, M.D.

Drugs of Choice 1964-1965

Edited by Walter Modell, M.D., 1018 pp., $16.75, The C. V. Mosby Co., 1964.

THIS IS ONE OF SEVERAL books concerned with the medical treatment of disease. It gives excellent advice for the treatment of the disorders which confront physicians. It is easily read, and comprehended although, as in most texts with many authors, some sections are less lucid than others.

Of course, the treatment as outlined is that favored by the author and in the case of many investigators there is much emotional involvement with "their" treatment. Hence, the material cannot be accepted blindly. It goes without saying, in addition, that the usefulness of such texts is limited to 12 months at the most.

The book is an excellent reference and does provide a ready consultation with an expert regarding the treatment of most disorders.

M. G. BOTTICELLI, M.D.

A Doctor Talks to 9-to-12 Year Olds

By Marion O. Lerrigo, Ph.D., in consultation with Michael A. Cassidy, M.D., 75 pp., $1.50, Budlong Press Company, 1964.

IN THE AREA of psychosexual education of pre-teenagers there are really very few genuinely good aids in booklet form. The problem in this area is the complexity of each individual child's existing state of awareness, making any single standard approach to the problem difficult. A nine-year-old boy with three teen-age siblings is probably more widely and deeply informed than a 12-year-old only child. Furthermore, the depth of interest varies within the age group from a child completely satisfied with a one-sentence explanation of a cesarean section (available in any dictionary) to one who is genuinely interested in the predisposing factors, the comparative risks, and the prognosis of such an undertaking. These and other problems make the counselling problem in this age group far more complex than any booklet can answer.

It is a very good review of psychosexual and social aspects of sexual education. I feel it is too detailed in its discussion of cells, for instance of DNA and cytoplasmic composition, and would probably bore all but the intellectually sophisticated nine-to-twelve year olds.

There is a unique feature about this booklet: a pull-out companion booklet for the parents to read. In the final pages of this 27-page insert are suggestions on how to discuss these matters with children. This is very good but could stand to be greatly enlarged, with more examples, at the expense of all the preceding pages, which are almost a re-hash of what the main booklet discusses.

Recommended for parents and teenagers but only for the most intellectual pre-teenager.

JOHN R. STEPHENSON, M.D.

★A Practical Manual for the Treatment of Burns

By Eli Rush Crews, M.D., M.S., 119 pp., $6.75, Charles C. Thomas, 1964.

THIS BOOK is excellent for what it purports to be. It describes very concisely the entire treatment of burns, from first aid to late care. Both fluid therapy and local management are sensibly and simply described. I would recommend it to anyone who is concerned with the care of burn patients.

One minor criticism of the book is that it has many typographical errors.

T. K. TAIRA, M.D.

★Current Pediatric Therapy

By Sydney S. Gellis, M.D., and Benjamin M. Kagan, M.D., 747 pp., $16.00, W. B. Saunders Company, 1964.

THIS THERAPEUTIC "recipe book" has been long awaited by practitioners who treat children. For the common variety of childhood diseases and problems we see in practice, we have pet routines of therapy which have become part of us through years of experience and source of habit. We may polish them a little bit if we become impressed by "pearls" given us by a visiting professor or an outstanding article in the JOURNAL. It is nice to know that whatever we do for our patients falls in line with the most acceptable methods. In addition, we can't always remember the entire routines for the

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New Members



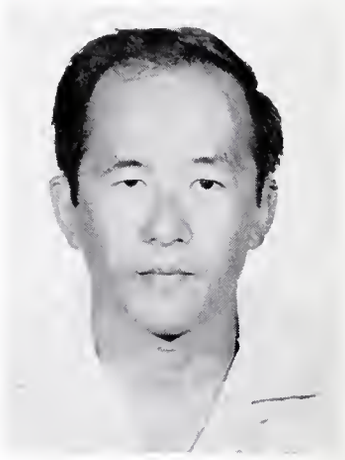
Elmars M. Bitte, M.D.

888 South King Street
Honolulu, Hawaii 96813
ANESTHESIOLOGY
Universities of Riga, Latvia, and Ludwig-Maximilian of Munich, Germany
Internship—St. Joseph's Hospital
Residency—Cleveland Clinic Hospital



Grover J. Liese, M.D.

The Queen's Hospital,
Radiology Department
Honolulu, Hawaii 96813
RADIOLOGY
Washington University School of Medicine
Internship—The Queen's Hospital
Residency—Stanford University Hospital



Peter Larm, M.D.

1744 Liliha Street
Honolulu, Hawaii 96817
ALLERGY
University of Erlangen
Internship—St. Francis Hospital
Residency—V. A. Hospital, Dearborn, Michigan



John M. Zelko, M.D.

139 Kinoole Street
Hilo, Hawaii 96720
OPHTHALMOLOGY
McGill University Medical School, 1956
Internship—Detroit Receiving Hospital, Detroit
Residency—Hospital of the University of Pennsylvania, Philadelphia
Gorgas Hospital, Canal Zone



H. William Goebert, Jr., M.D.

888 South King Street
Honolulu, Hawaii 96813
NEUROSURGERY
Hahnemann Medical College, 1957
Internship—Cleveland Clinic
Residency—Cleveland Clinic



Eldon Raymond Dykes, M.D.

888 South King Street
Honolulu, Hawaii 96813
PLASTIC SURGERY
University of Tennessee College of Medicine, 1952
Internship—Philadelphia General Hospital
Residency—Cleveland Clinic Hospital

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County Society News



Joseph Oren, M.D.

4614 Kilauea Avenue
Honolulu, Hawaii 96816
PEDIATRICS
Cornell University Medical College
Internship—Strong Memorial Hospital
Residency—Strong Memorial Hospital



William J. Natoli, M.D.

888 South King Street
Honolulu, Hawaii 96813
OBSTETRICS & GYNECOLOGY
University of Rochester, 1946
Internship—Barnes Hospital,
St. Louis, Mo.
Residency—Barnes Hospital,
St. Louis, Mo.

Honolulu

Four new members were welcomed into the Society at its April 7 meeting—Drs. Frank S. Akamine, Henry H. C. Fong, William O. Kirker, and H. C. Nordstrom.

The chair announced that the increased membership entitled HCMS to two more delegates to the HMA. Drs. Francis Au and Douglas Bell, Jr., were moved up to regular delegates and Drs. Claude V. Caver and Marcelino J. Avecilla were named alternate delegates. Dr. Calvin Sia reported on the existing problems at Children's Hospital.

The proposed bylaw changes pertaining to provisional membership and dues waiver were passed.

The meeting ended with a panel discussion on "Fundamentals of the Stock Market." Dr. Robert T. Wong was the moderator and Messrs. Karl Heyer, Richard Lim, and John Bolman participated.

* * *

There was no Honolulu County Medical Society meeting in May.

* * *

The June 3 membership meeting featured a panel discussion on "Projection of the Economy of Hawaii for the Next Ten to Fifteen Years," which Dr. Walter Y. M. Chang moderated. Discussants were Thomas Hitch, James H. Shoemaker, and Harry Oshima.

The following new members were welcomed into the Society: Drs. Peter Larm, Joseph Oren, and Grover J. Liese, who was not present.

Dr. Allan Leong announced that the Medical Practice Committee had received complaints relative to requests for consultation by insurance companies or lawyers. He asked that the members keep in mind that (1) the treating physician must not discourage the patient from visiting the consultant requested by the third party; (2) that the consultant, as a matter of courtesy, should notify the physician that he will see the patient; and (3) that the findings of the consultant cannot be released to anyone except the employing insurance company or lawyer.

Dr. Mor James McCarthy presented for first reading some proposed bylaw changes.

The meeting concluded with an address by AMA President Edward R. Annis.

Kauai

Four guest speakers, Drs. Robert Nordyke, Carl Boyer, Allen Leong, and Edward Jim, presented papers at the April 7 meeting. Other guests were Dr. Verne Waite and Mr. J. R. Veltmann.

The Society unanimously approved the appointment of Dr. Edward W. Boone as Assistant Medical Director of HMSA. In response to an inquiry from Dr. Francis Nance of Honolulu, it was voted to reaffirm the Society's approval and desire to have him continue his visits to Kauai. The Secretary was instructed to write a letter to the G. N. Wilcox Memorial Hospital asking that Society's endorsement of Dr. Nance be presented to its medical staff.

It was voted to approve Dr. Rosen's application to practice on Kauai. It was voted to invite Mrs. Arlene Young to a Society meeting in order that she can present her proposed mother-and-baby care program. The Society went on record as approving the proposed survey of the Department of Health to determine the extent of certain

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Hawaii Medical Association

HAWAII MEDICAL ASSOCIATION COUNCIL MEETING

April 8, 1964—6:00 P.M.
Oahu Country Club, Honolulu

PRESENT

Dr. Rodney T. West, presiding; Drs. Allison, Andrews, Chinn, Lum, Miyamoto, Nishijima, and Wade, plus guests Drs. Richardson, Fujii, county society presidents; Dr. George Mills, Chairman of the Medical Care Plans and Fees Committee; Dr. John F. Chalmers, Chairman of the Legislative Committee; and Mr. Tom Thorson.

MINUTES

The minutes of the March 4, 1964, meeting were circulated. Dr. Bernard Fong's name was omitted in error. The minutes were approved as corrected.

COMMUNICATIONS NOT REQUIRING ACTION

Mabel Smyth Bldg: Dr. West asked Dr. Richardson to comment on communications exchanged relative to Mabel Smyth Building space requirements. Dr. Richardson said that at the present time Honolulu County is not too enthused about going ahead in building the basement.

COMMUNICATIONS REQUIRING ACTION

St. Francis Hospital: A copy of a letter from Sister Maureen, Administrator of St. Francis Hospital, to Mr. Frank Keifer was reviewed. In the letter, Sister Maureen states that legislative activities of hospital organizations and the Medical Association would be enhanced if a channel of communication could be maintained to discuss areas of mutual interest. Dr. Chalmers stated that Sister Maureen was unhappy about the budget situation and the fact that there seemed to be divergence of opinion relative to the care of indigent patients.

REPORT OF THE SECRETARY

The Secretary's report was noted.

ACTION:

It was voted to accept the Secretary's report as circulated.

REPORT OF THE TREASURER

The Treasurer's report was discussed at length.

ACTION:

It was voted to purchase drapery and carpets for the HMA offices to improve the acousties.

It was voted that both of the Treasurer's recommendations be accepted.

It was voted to accept the Treasurer's report as circulated with the recommendations.

UNFINISHED BUSINESS

Solicitations: Mr. Tom Thorson gave a report on the Oahu Health Council. It was noted that the Oahu Health Council does not evaluate voluntary health agencies. The Better Business Bureau will advise if they have received complaints but will not give this information out over the telephone. The Chamber of Commerce has a Solicitation Control Committee which could investigate an organization at a member's request if it were firmly convinced there was a need for the investigation.

Interim meeting on the neighbor islands: It was noted that substantial portion of the membership is interested in having an interim meeting on a neighbor island.

Rental Charges for HMA executive offices: It was suggested to invite Dr. H. Q. Pang to the next Council Meeting. It was also suggested to write a letter regarding rental charges.

Poll of members regarding the Medical Practice Act: The previous action of the Council was felt to be premature.

ACTION:

It was voted to postpone the membership poll regarding changes in the Medical Practice Act.

NEW BUSINESS

Committee Responsibility: Dr. Allison suggested that each committee should come up with an outline of its particular function so that the incoming committees will know what to do. The present chairman of each committee should include in his final report the function of the committee. Each chairman should list the duties of the committee on a separate sheet of paper.

ACTION:

It was voted to accept Dr. Allison's recommendation.

Annual Meeting Registration: It was noted that the Woman's Auxiliary cannot staff the registration desk on Wednesday and Saturday.

ACTION:

It was voted that the Executive Secretary hire an ancillary group if there is no voluntary help for annual meeting registration.

REPORTS OF STANDING AND SPECIAL COMMITTEES

Medical Care Plans and Fees Committee: Dr. Mills presented an up-to-date report on the activities of the Medical Care Plans and Fees Committee. Dr. Mills suggested that Dr. West and Dr. Allison attend the meeting of the Medical Advisory Committee to the Medical Payments Program of DSS. He also reported on the effect on the hospitals of the Legislature's mandates. Both reports are on file in the Association offices.

Legislative Committee: Dr. Chalmers quoted from his final report to be presented to the House of Delegates. The Nurses' Association has asked to sit in with the HMA Legislative Committee when they meet. He read the resolution of the Legislative Committee regarding the pharmacists. Dr. Chalmers said that the Legislative Committee would like to make a recommendation to the House of Delegates to make a very strong stand on the pharmacy legislation.

ACTION:

It was voted to advise the Delegate to the AMA to continue to support the previous stand of the AMA that physician ownership of pharmacies is not unethical if exploitation of the patient is not the result.

Disaster Committee: There was a discussion on whether this committee should be on the county level. It was noted that memorandum on this subject was sent out to each county but no answer had been received. ■

RANDAL A. NISHIJIMA, M.D.
Secretary

HAWAII MEDICAL JOURNAL

Notes and News

New Offices for . . .

Dr. Peter Larm at 1744 Liliha Street, Room 206, Honolulu, for the practice of allergy.

Relocating are . . .

Dr. Robert Lee, Jr., to the First National Bank Building, 165 So. King Street, Honolulu.

Dr. Leslie Luke to the Central Medical Building, 1531 So. Beretania Street, Honolulu.

Dr. William W. L. Ahana to 1347 River Street, Room 15, Honolulu.

Dr. Rene Joyeuse to 45-1098 Kam Highway, Room 201, Kaneohe, for the practice of surgery (from Molokai).

Dr. Earl D. Lovett, Director of University of Hawaii Student Health Services, resigned his position to return to California where he will resume his work after a short vacation.

Names in the News . . .

Dr. Casimer Jasinski has been appointed to the position of Deputy Regional Flight Surgeon, Pacific Area, Federal Aviation Agency. He will work with **Dr. Albert Cierebiej** who heads the Division of Aviation Medicine for the FAA here.

Dr. Jose Rosal has transferred from Wake Island to Canton Island where he will provide medical services to the employees and natives there with the assistance of only one R.N.

Dr. Guy William Heder plans to leave his FAA Wake Island post to locate in Kahuku.

Dr. Edward R. Annis, president of AMA, spent a busy week in Hawaii.

"Local Boys" make good! Outstanding among the many who have chosen a home on the mainland are **Dr. A. K. Saiki,** Professor of Pathology at Grand Forks, N. D.; **Dr. Richard Blaisdell,** Assistant Professor of Hematology, University of Chicago; and **Dr. Samuel S. Koide,** a cancer researcher at Sloan Kettering Institute.

Dr. Robert Spencer has warned the Department of Education that if the teacher's job is eliminated at State Hospital, he may have to stop admission of mentally disturbed youngsters to the hospital.

Dr. Edward Boone has been named the Assistant Medical Director of HMSA. He will assist **Dr. Verne C. Waite,** who is the Medical Director.

Dr. Chew Mung Lum and **Dr. Cesar de Jesus** have been named to the Board of Health.

A two-page spread in *House and Garden* featured the home of **Dr. James Harrison.** Also in same issue was the home of **Dr. Pershing Lo.**

Medical Assistant of the Year award was presented to **Mrs. Helen M. Torricer** by **Dr. Edward Annis,** president of AMA. Mrs. Torricer has worked for **Dr. R. Varian Sloan** for six years.

Training classes for asthmatics have been organized on Kauai by **Dr. Peter Kim,** under the sponsorship of TB and Health Association of Kauai. The students will learn the proper methods of breathing in order to avoid shortness of breath.

In a half-page ad in the *Garden Isle News* Frank Sinatra thanked all the people and organizations who took a part in saving his life from drowning on Kauai. Among these **Dr. Patrick Cockett.**

Mrs. John Martinsen has been chosen to head the Hawaii Medical Library. She holds degrees in both nursing and library arts. During World War II she was an Air Evac nurse, escorting casualties from Guam, Leyte, Saipan, and Okinawa.

Retiring from the Health Department after 36 years of service was **Mr. Robert L. Lam,** Sanitary Engineer Supervisor. Over 200 people attended the Aloha dinner at Lau Yee Chai. **Dr. Leo Bernstein,** State Director of Health, cited Mr. Lam for outstanding service to public health.

Newly appointed to the Board of Medical Examiners are **Dr. Willis P. Butler** and **Dr. Thomas S. Min.**

JAY M. KUHNS, M.D.
1884 - 1964

Dr. Jay M. Kuhns died in The Queen's Hospital on April 1, 1964, leaving many friends and former devoted patients to mourn his departure.

Dr. Kuhns was born in North Dakota on September 13, 1884, and came to Hawaii with his parents and several brothers and sisters, at the age of 14, to live on a homestead near Hilo. In his early years he engaged in many occupations, such as teaching school, working on sugar plantations, and acting as a cowboy on Parker Ranch, in order to gain sufficient funds to further his education. He attended McKinley High School, spent two years at the University of Hawaii, and entered Washington University Medical School in 1911 at the age of 27. After graduating in 1915, he married Eula Urban, who was secretary to his Professor of Anatomy. As a honeymoon trip they came to Hawaii, where Dr. Kuhns began an internship at The Queen's Hospital, later becoming Chief Resident before relinquishing these duties to become the plantation physician for Makee Sugar Company at Kilauea, Kauai. Four years later he moved to Lihue to act in a similar capacity for Lihue Plantation. After 22 years in this capacity, he entered private practice in Lihue, retiring in 1961.

Dr. Kuhns was elected President of the Hawaii Medical Association in 1947, and in 1958 he was named "General Practitioner of the Year" by the House of Delegates of this Association, the first physician to receive this signal honor.

Dr. Kuhns is survived by his wife and one daughter, Mrs. Fred Hebert, who lives in Lihue, and four grandchildren. His surviving sisters are Mrs. D. Thaanum and Mrs. A. Hansen of Honolulu, and Mrs. Bessie Bell of San Francisco.

Much could be written about Jay Kuhns, for he was a most colorful individual: widely traveled, well read, and interested in many things outside his profession. The life of a plantation physician was especially suited to his approach to life; he liked the open spaces and the informality of such an existence. His early life was spent among plantation employees, and therefore he could speak their language and understand their problems, and he was never so happy as when ministering to their needs, even though he well knew his only recompense, at times, would be their eternal gratitude.

J. E. Strode, M.D.

Notes and News

The Honolulu General Surgical Society elected new officers at its meeting held recently at Tripler. They are **Dr. Wallace W. S. Loui,** President; **Dr. Francis Au,** Vice President; and **Dr. James W. Cherry,** Secretary-Treasurer. Principal speaker was **Dr. William Anlyan,** who is Professor of Surgery at Duke University. Prizes for essays were awarded to **Dr. John Withers** of Tripler who won first place with his essay on Pneumothorax, Suggested Etiology and Comparison of Treatment Methods, and **Dr. Kazushi Tanaka** and **Dr. Manual Abundo,** both from Queen's, who tied for second place with essays on Complete Vascular Ring Causing Tracheal and Esophageal Compression, and Experiences in Honolulu with the Revised Combined Operation for Duodenal Ulcer.

Health Tips . . .

State Health Department Epidemiologist **Dr. W. F. Lyons** stated that Hawaii has had two deaths from tetanus in the last year. Active immunization is the best way to prevent this disease. A human antitoxin serum (in lieu of horse serum) is now available for treatment of this disease. Also announced was the upswing of chickenpox, gonorrhea, infectious hepatitis, and German measles.

A five-day session, the annual meeting of the American Dermatology Association, was held at Kaanapali.

Seminar on Community Health Mobilization was held here June 26-28 sponsored by HMA and Department of Public Health. Visiting experts included **Dr. Gabriel Ferrezano,** chief of the division of Health Mobilization, and **Mr. Robert Brook,** program representative from San Francisco. Following the event, a reception for the visitors was held at the ocean front Lanikai home of **Drs. Casimer and Doris Jasinski.**

Cancer of the cervix took the lives of 17 women in Hawaii last year. The simple "Pap" smear done in time could have prevented this, states **Dr. W. S. Lummis, Jr.,** Executive Officer, Medical Health Services Division of the State Health Department. These tests are now available at Queen's, St. Francis, and Kapiolani Hospitals outpatient departments to those women who can't afford a private doctor.

Some 100 scientists from all over the world will meet here January 24-29, 1965, at a National Institute of Health Cholera Advisory Committee symposium session to be held at the East-West Center, which will co-host the event with the Pacific Biomedical Research Center of University of Hawaii.

Happy Notes . . .

It's wedding bells for Diane Devereux, daughter of **Dr. and Mrs. John Devereux.** The lucky man is Philip Bayles of Chicago.

Mark Thomas Richert, son of **Dr. and Mrs. Thomas H. Richert,** was wed to Mary Glenn Peabody of Riverside, California. The couple will live in La Jolla, Calif.

Two young Hiloans now in medical school will again be recipients of the Hawaii County Medical Society Scholarship Funds. They are **Thomas Eshelman** and **Wilfred Fujimoto.**

Four daughters of **Dr. and Mrs. Andrew Ivy** brought home six medals for individual events they swam in the State Swim Championships at Hilo.

Mayor Blaisdell has announced a 1.3 million dollar expansion and renovation for Maluhia Hospital to take place over the next four years.

Newlyweds honeymooning at the Princess Kaiulani and on the neighbor islands were **Dr. and Mrs. Francis Oda.** Mrs. Oda is the former Anna Wall from Medford, Mass.

Placement Service . . .

Aviation Medical Examiners are needed on the neighbor islands (especially, Molokai, Hawaii, and Lanai), and Samoa. Those interested contact **Dr. Albert Cierebiej,** Federal Aviation Agency, Honolulu.

A locum tenens is needed for Kauai from September 15 through October 7. Must be licensed. Several plantations are looking for locum tenens and permanent physicians. Call Mr. Bush at Theo. H. Davies and Mrs. Nelson at Castle & Cooke. Licensed physician would like to take off one year from his pediatric orthopedic residency and return to work in Hawaii. Young, recently licensed general surgeon looking for full-time association.

Large medical group is looking for an ophthalmologist and a physician who specializes in industrial medicine.

Hawaii Department of Public Health

COMMUNICABLE DISEASES IN HAWAII
April-May, 1964

DISEASE	APRIL 1964	MAY 1964	FIVE-YEAR MEDIAN
Chancroid	—	1	<1
Chickenpox	310	339	106
Conjunctivitis, Infectious	—	8	1
Dysentery, Amebic	—	1	<1
Dysentery, Bacillary	—	—	10
Fifth Disease	—	2	—
Gonorrhea	44	57	19
Hansen's Disease	—	3	1
Hepatitis, Infectious	5	9	3
Hookworm Disease	—	—	<1
Impetigo	10	9	—
Influenza	871	818	40
Measles	88	70	58
Measles, German	27	66	10
Meningitis, Aseptic	4	2	<1
Meningitis, Meningococcic	5	—	<1
Meningitis, Hemophilus	—	1	—
Meningitis, Mumps	2	—	—
Meningoencephalitis	—	—	—
Mumps	675	505	73
Mononucleosis	19	1	<1
Pneumonia, Infectious	9	2	19
Rheumatic Fever	—	—	<1
Salmonellosis	10	20	16
Scarlet Fever and Strep. Sore Throat	323	245	12
Syphilis, Primary and Secondary	2	2	1
Syphilis, Early Latent	2	3	1
Syphilis, Late and Late Latent	17	13	6
Tetanus	—	—	<1
Trichinosis	—	1	<1
Tuberculosis	23	12	NA
Typhus Fever Murine	—	1	<1
Weil's Disease (Leptospirosis)	—	—	<1
Whooping Cough	4	—	<1

Comments

A_2/Jap/305/57 strain of influenza was isolated from nine patients on Oahu and Kauai, and ECHO 6, 11, and 14 strains from three patients complaining of the "flu" during March, April and May, 1964.

Conjunctivitis, infectious hepatitis, influenza like syndrome, German measles, mumps and streptococcal diseases are all in epidemic numbers. Seventeen of the 20 cases of infectious mononucleosis were from military reports.

Infectious syphilis continues highest since 1951 when the disease was classified into infectious and latent. The male homosexual population of Honolulu produces 50 per cent of the cases.

Hawaii Doctors in Print . . .

Complete Heart Block in Infants and Children was the title of an article of which **Dr. Frances F. Nakamura** is one of the authors. It appeared in the June 11 issue of the *New England Journal of Medicine.*

Miscellaneous . . .

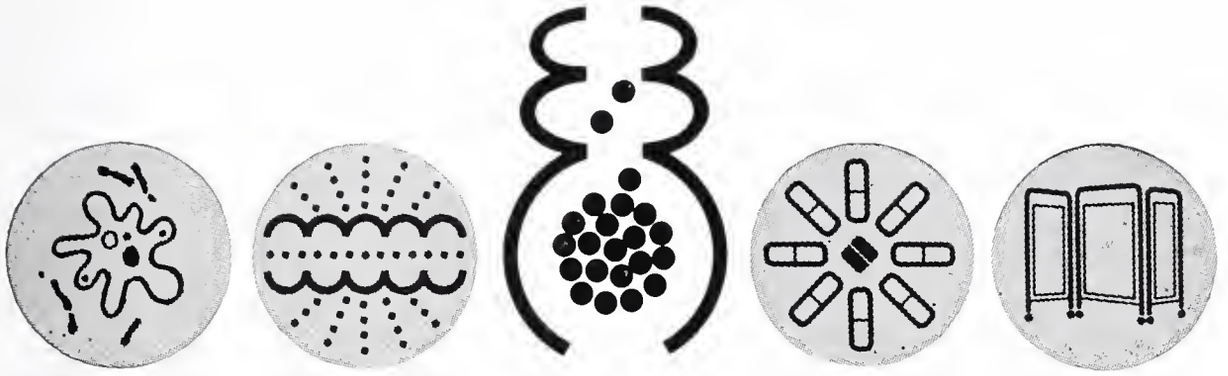
Mr. Floyd C. Carrier, Executive Director of the Council on Alcohol Problems of Hawaii, states that alcoholism is a form of addiction and that there are at least 60 al-

continued page 522

in virtually all diarrheas... prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

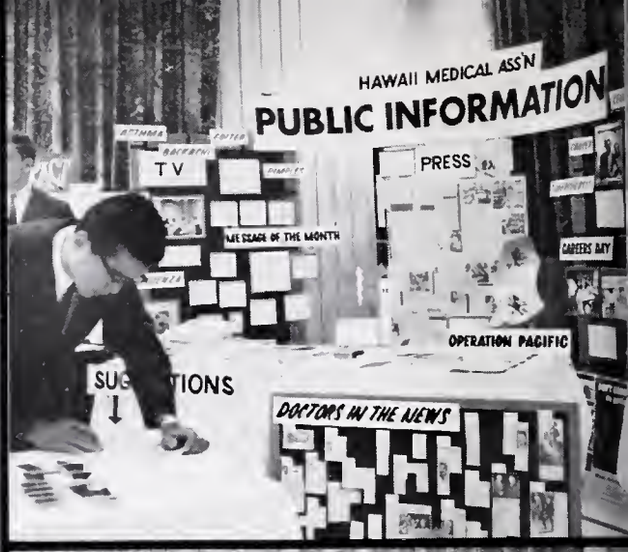
The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE









HAWAII MEDICAL ASSOCIATION

108TH ANNUAL MEETING

APRIL 30 - MAY 3
1964








ANTHROP









Our New President

Concern for the well-being of his fellow man comes naturally to our new President, Samuel Dudleston Allison. His middle name is that of his mother, a Methodist missionary from Ithaca, New York, who met the Reverend Samuel Allison, a Methodist minister from England, while she was teaching school in Utah. Sam was born in Eureka, Utah, on May 10, 1911, but had his raising and schooling in Aberdeen, Utah, and Glenn's Ferry, Idaho. He received his M.D. degree from the University of Oregon Medical School in 1936 and his Master's in Public Health from Johns Hopkins in 1941.

While in medical school, he met Cecil McCready, a music student, and they were married in 1937. Their only child, Kathryn Lynn, will enter her senior year at Connecticut College in New London this fall.

In February, 1942, Sam became Venereal Disease Control Officer for the Hawaii Territorial Department of Health. Within two years, the incidence of VD here had dropped so low that—statistically—a soldier stationed here would not be expected to acquire a venereal infection until he had been here two hundred years; and prostitution had been outlawed in fact as well as on the law books. Hawaii had taken a huge lead on the rest of the world, including "America," in the eradication of VD.

Despite Sam's rapid advancement in the Department of Health, his interest was turning toward medical practice, and in 1947 he resigned as Director of Preventive Medicine to take postgraduate training in dermatology at Bellevue Hospital in New York. He returned to Honolulu in the fall of 1948 and has been practicing dermatology here since that time.

Public service has occupied much of his spare time. He is a past president of the Hawaii Public Health Association, the Mental Health Association of Hawaii, the Waikiki Rotary Club, and the Johns Hopkins Association of Hawaii; he has been active in the Cancer Society, the Oahu Health Council, the Public Health Committee of the Honolulu Chamber of Commerce, and the Hawaiian Academy of Science. He is the author of some 40 published articles on medical history, venereal disease control, dermatology, and combinations of these, and has collaborated in the writing of a book and four pamphlets on venereal disease control.

In the Honolulu County Medical Society, he has had long service on its Postgraduate, Library, Public Service, Medical Practice, and Nominating Committees, and has served as a member of its Board of Governors (1958) and a trustee of the Honolulu Foundation for Medical Care (1961). In the Hawaii Medical Association he has served on countless committees, notably Scientific Program, Public Relations, Public Service, and Legislative, and was elected Secretary in 1962.



Kauka Pohaku

The Allisons sold their attractive home on Black Point last year, and are now awaiting completion of a new home of their own design, built on lava rocks sculptured by Sam's experienced hand and the sweat of Sam's own brow, as the picture shows. The new home will cantilever out over the water at Kaikoo, high on the Diamond Head side of Black Point.

None who know Sam doubt that the Association will be carefully and firmly guided during the coming year. The appointment of all committees by the time he assumed office typified the careful planning and promptness Sam brings to all his projects.

We hope Sam will stay here a long time—indefinitely, in fact. But if the time-honored advice to "Go West, young man," ever strikes him as good, he is one of the few Hawaii doctors who could do it. In 1952, during an official visit to Taiwan under WHO auspices, he acquired a license to practice medicine there! ■

108TH ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

HONOLULU, HAWAII
April 30 through May 3

The annual meeting for the one hundred and eighth year of corporate existence of the Hawaii Medical Association was held in Honolulu in 1964. The following program was presented:

SCIENTIFIC PROGRAM

Premeeting Events

Fireside Chats—sponsored by the Hawaii Thoracic Society and the American College of Chest Physicians, Hawaii Chapter, in cooperation with the Hawaii Medical Association, American Heart Association, Hawaii Chapter, and the American Therapeutic Association, Hawaii Chapter

Panel Discussions

Causes of Cardiovosculor Disease
Moderator: Dr. Irvine H. Page
Panelists: Drs. John J. Kelly, Francis Nakamura, Dudley S. J. Seto, William F. Sheeley, Laurence H. Snyder

Detection of Cardiovascular Disease I
Moderator: Dr. A. S. Hartwell
Panelists: Drs. Bernard W. D. Fong, Frank L. A. Gerbode, Abraham Kagan, O. D. Pinkerton, John R. Stephenson

Detection of Cardiavascular Disease II
Moderator: Dr. Morton E. Berk
Panelists: Drs. Edward L. Chesne, Unoji Goto, George W. Henry, John J. Kelly, Robert A. Nordyke, Edwin J. Wylie

Prevention of Cardiavascular Disease I
Moderator: Dr. John J. Kelly
Panelists: Drs. David Bassett, L. T. Chun, Thomas E. Starzl, Sorrell H. Waxman, Robert M. Worth

Prevention of Cardiavascular Disease II
Moderator: Dr. Frank L. A. Gerbode
Panelists: Drs. John A. Harbinson, Winfred Y. Lee, George H. Mills, J. I. F. Reppun, Gerald Rosenblatt

Medical Treatment of Cardiavascular Disease
Moderator: Dr. Frank L. A. Gerbode
Panelists: Drs. Donald F. B. Char, John J. Kelly, Richard T. Mamiya, Coolidge S. Wakai, Bernard J. B. Yim

Surgical Treatment of Cardiavascular Disease
Moderator: Dr. Irvine H. Page
Panelists: Drs. Scott C. Brainard, Frank L. A. Gerbode, John J. Kelly, Niall M. Scully, Thomas E. Starzl, Edwin J. Wylie

Papers

Definition of the Cardiavascular Problem, 1964
Dr. Irvine H. Page

Organ Transplants
Dr. Thomas E. Starzl

Presidential Address
Dr. Rodney T. West

SOCIAL PROGRAM

Cocktails and Dinner Dance, Oahu Country Club
Picnic for physicians, at the home of Dr. Ralph B. Cloward

MEETINGS

House of Delegates, Mabel Smyth Bldg.
Fireside Chats, Mabel Smyth Bldg.
Scientific Program, Princess Kaiulani Hotel
Woman's Auxiliary, Kahala Hilton Hotel

PARTICIPATING DELEGATES

Hawaii County:
Ruth E. Oda

Kauai County:
Peter Kim

Maui County:
Marion Hanlon
Edmund A. Tompkins

Honolulu County:
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Grover H. Batten
Ralph M. Beddow
Douglas B. Bell, II
Morton E. Berk
Charles S. Brown
Walter Y. M. Chang
Kenneth Chinn
William W. L. Dang
A. S. Hartwell
Gail G. L. Li
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HAWAII MEDICAL ASSOCIATION

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Tadao Hata 1966
W. J. Holmes 1965
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Niall M. Scully 1966
Calvin C. J. Sia 1964
Tom K. Taira 1966
Paul T. Caldwell, Hawaii 1965
Ruth E. Oda, Hawaii Alt. 1965
M. A. Brennecke, Kauai 1965
Clyde H. Ishii, Kauai Alt. 1965
W. B. Patterson, Maui 1966
Marion Hanlon, Maui Alt. 1966
Edwin D. Willett, Lanai 1965
Paul G. Stevens, Molokai 1966

Date indicates year term expires.

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Norman R. Sloan
Harold Lewis, Hawaii
Peter Kim, Kauai
Kenneth A. Haling, Maui

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Robert C. M. Chung
Gail G. L. Li
F. J. Pinkerton
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R. P. Wipperman, Hawaii
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B. A. Richardson, Honolulu
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M. A. Brennecke, Kauai 1965
Clyde Ishii, Kauai Alt. 1965
W. B. Patterson, Maui 1966
Marion Hanlon, Maui Alt. 1966
E. D. Willett, Lanai 1965
Paul G. Stevens, Molokai 1965

In addition, the following former committee chairmen are ex officio members:

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Fugate Carty — J. I. F. Reppun
Duke Cho Choy — K. S. Tom
Fred Lam, Sr. — Clarence A. Wyatt
F. D. Nance

* Denotes members of Perinatal Mortality Study Subcommittee. Date indicates year term expires.

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Kazuo Teruya

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Paul Y. Tamura
K. S. Tom, Vice Chairman
Henry H. L. Yim

PR Subcommittee, TV-Radio
Walter Y. M. Chang, Chairman
Herbert Y. H. Chinn
James T. Kuninobu
Robert G. Rigler
Doris R. Jasinski
Patrick J. Walsh

Radiation Committee
George W. Henry, Chairman
Edgar S. Childs
Robert Katsuki
Philip J. W. Lee
Robert A. Nordyke
John M. Ohtani
Francis N. Terada
Peter J. Washko
George Bracher, Hawaii
P. M. Cockett, Kauai
Raymond Otsuka, Maui

Scientific Program Committee
Fred I. Gilbert, Jr., Chairman
James W. Cherry
Casimer Jasinski
Robert T. S. Jim
Robert Kim
George Suzuki
Paul Y. Tamura
Frederick B. Warshauer
Francis Wong, Hawaii
M. A. Brennecke, Kauai
Clifford F. Moran, Maui

School Health Committee
Calvin C. J. Sia, Chairman
Jeanette H. J. Chang
Robert G. Dimler
Katherine J. Edgar
Doris R. Jasinski
Laurence Lit Lau
Donald C. Marshall
John C. Milnor
Nathan Shklov
Henry H. L. Yim
Ewart S. Sarvis, Hawaii
Clyde Ishii, Kauai
Marion Hanlon, Maui

Tuberculosis Committee
Charles S. Brown, Chairman
John F. Harbinson, Jr.
S. R. Horio
Herman P. Kramer
Wallace W. S. Loui
Robert H. Marks
Clifford K. Mirikitani
Tetsui Watanabe
James A. Mitchel, Hawaii
Peter Kim, Kauai
Edmund A. Tompkins, Maui

Venereal Disease Committee
Robert K. Mookini, Chairman
Samuel J. Buist
John F. Chalmers
Cesar B. de Jesus
K. S. Fong
Ira D. Hirschy
Robert Kim
Wilfred H. Kurashige
Linus C. Pauling, Jr.
S. Kasamoto, Hawaii
Peter Kim, Kauai
F. H. Tong, Maui

Woman's Auxiliary Liaison Committee
A. L. Vansconcellos, Chairman
Robert Y. Katsuki
Francis H. Soon
R. P. Henderson, Hawaii
Clyde Ishii, Kauai
Lester Kashiwa, Maui

Nominating Committee
R. P. Moore, Chairman
Frederick L. Giles
Allan Leong
Carl Mason
T. T. Tomita, Vice Chairman
James A. Mitchel, Hawaii
P. M. Cockett, Kauai
J. A. Burden, Maui

AD HOC & SPECIAL COMMITTEES

Association of Professions
A. Leslie Vasconcellos, Chairman
W. Harold Civin
R. T. Kainuma
M. H. Lichter
Robert Miyamoto, Hawaii
K. Fujii, Kauai
Joseph E. Andrews, Maui

Examining Board for Hansen's Disease
Michael Okihiro

Board of Management, Mabel Smyth Bldg.
Toru Nishigaya 1964
H. Q. Pang 1965
Donald C. Marshall, Alt. 1964

SPECIAL APPOINTMENTS

The National Foundation's Health Scholarship Committee—C. M. Burgess
Inter-Professional Coordinating—Leabert R. Fernandez, Theodore T. Tomita
Oahu Health Council—E. F. Cushnie, Unoji Goto
Advisory Committee to the Division of Mental Health—K. Y. Lum
Advisory Committee to the University of Hawaii—Bernard W. D. Fong
Medical Advisory Committee to the Department of Social Services—Clifford T. Druecker, George H. Mills, George H. Nip, Keith F. O. Kuhlman, William N. Bergin, J. Alfred Burden, Patrick M. Cockett

PROCEEDINGS OF THE HOUSE OF DELEGATES

108th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, Rodney T. West, at 1:15 P.M., April 30, 1964, in the Mabel Smyth Auditorium, Honolulu.

Present were (officers) Rodney T. West, Samuel D. Allison, Herbert H. Y. Chinn, Randal A. Nishijima; (councillors) Robert M. Miyamoto, Bernard W. D. Fong, Chew Mung Lum, O. D. Pinkerton; (Hawaii delegate) Ruth E. Oda; (Honolulu delegates) Francis T. C. Au, Grover H. Batten, Ralph M. Beddow, Douglas B. Bell, II, Morton E. Berk, Charles S. Brown, Kenneth Chinn, William W. L. Dang, A. S. Hartwell, Gail G. L. Li, Andrew L. Morgan, Richard S. Omura, Richard D. Moore, L. Q. Pang, R. Frederick Shepard, R. Varian Sloan, Theodore T. Tomita; (Kauai delegate) Peter Kim; and (Maui delegates) Edmund A. Tompkins and Marion Hanlon.

Honolulu President B. A. Richardson asked that the following alternate delegates be seated to complete Honolulu County's delegation: Marcelino J. Avecilla for Warren L. H. Wong, Walter Y. M. Chang for Unoji Goto, Robert K. Mookini, Jr., for Bernard J. B. Yim, Coolidge S. Wakai for Carl B. Mason, John R. Watson for Walter M. Ozawa, and Carolina D. Wong for Robert T. S. Jim.

The minutes of the May 2-6, 1963, and September 7-8, 1963, meetings were approved as published.

The reports of the President, Secretary, and Treasurer, as well as those of the county societies which were received prior to the meeting were referred to the Reference Committee on Parliamentary Affairs.

The reports of the standing and special committees were referred as indicated in the Delegates' Handbook.

Resolutions entered prior to the meeting were referred as indicated in the Handbook. One additional resolution (#8) was assigned to the Reference Committee on Parliamentary Affairs.

The President made the following changes in the Reference Committee make-up: Parliamentary Affairs—Carolina Wong for Robert T. S. Jim, Bernard W. D. Fong for Walter S. L. Loo, John R. Watson for Walter M. Ozawa. Insurance and Medical Service—Robert M. Miyamoto for Nicholas Steuermann. Public Health—Robert K. Mookini, Jr., for Bernard J. B. Yim. Miscellaneous Business—Walter Y. M. Chang for Unoji Goto, and Edmund A. Tompkins for Edward Underwood.

The Treasurer pointed out that the budget in his report covered only operating expenses and that the difference between these expenses and the anticipated income is $23,920. The total amount of money requested by the individual committees was $28,040.00 or a difference of $4,120.00.

The Honolulu Delegation asked its members to meet for a ten-minute caucus and the House recessed for deliberation of the reference committees at 1:45 P.M.

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The second session of the House of Delegates was called to order on Friday, May 1, 1964, at 2:00 P.M. The Secretary called the roll. Alternate Delegate Yonemichi Miyashiro was seated for Peter Kim of Kauai County. No additional alternates were seated for any of the other counties.

INSURANCE AND MEDICAL SERVICE REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately twelve physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

CRIPPLED CHILDREN COMMITTEE

The annual meeting of this Committee was held on April 3, 1964, at the Mabel Smyth Building.

Following is the report of this Committee:

REPORT OF LABORATORY AND RADIOLOGY FEES WITH HOSPITALS: The 1963 House of Delegates rejected the suggestion of this Committee that the Crippled Children Section negotiate directly with the Hawaii Hospital Association on laboratory and radiology fees, and recommended that the Hospital Committee meet with the Hawaii Hospital Association to solve this problem. To date the Crippled Children Section has not heard of the results.

It was voted that the Hospital Committee be recontacted and submit its recommendations for the solution of this problem at the next annual meeting of the HMA.

FEES FOR NEW PROCEDURES: Occasionally a new procedure comes up which is not in the Relative Value Study. It takes time for the Medical Care Plans and Fees Committee to act on a fee for such a procedure.

It was voted that all new procedures not now listed in the Relative Value Study shall be set at the national average until a fee has been set by the HMA.

BUDGET FOR 1964-1965 FISCAL YEAR: The Crippled Children Section has not been able to get an increased budget to cover the cost of the increased fees since the Relative Value Study was used in June, 1962.

Dr. Bernstein stated that the Legislature has mandated the Department of Health to curtail the activities in maternal health, hospital and medical facilities, and health education. He anticipated that there would be more increases in education and more cuts in health. He added that it was urgent that the Committee take a long, careful look at what the Department of Health is doing. If there is anything that can be done elsewhere adequately, he would like to have the HMA's recommendations. If the Association thinks that the things the Department is doing are essential, the Department would like to have the Association's support.

The means test was also discussed. It was pointed out that the Crippled Children Section does not apply the means test for diagnostic work until after the first visit. Since most people have insurance, it was recommended by the Committee that the physicians be reminded to look into private resources before they go to the Crippled Children Section.

REHABILITATION SERVICES AT LEAHI HOSPITAL: The Finance Committee of the House of Representatives requested that the Department of Health "cooperate with the Finance Committee in attempting to make the best possible uses of Leahi Hospital facilities." In line with this request, facilities at the Trotter Unit have been studied as to their suitability for rehabilitation of certain children who have traumatic spinal cord injuries. One or two children are referred to CCS each year for total rehabilitation services. Trotter Unit has physical and occupational therapy and social services. Follow-up by physicians in private practice could also be arranged on a fee-for-service basis.

It was pointed out that the Department of Health is supporting the activities of the Rehabilitation Center. However, Leahi Hospital is a government service and CCS can save by using this facility.

The Committee agreed that this would be appropriate use of Trotter Unit facilities for CCS cases.

UNOJI GOTO, M.D.

As the Chairman of the Reference Committee read the report, it was noted that he did not follow the printed report which was circulated to the Delegates. The Chair-

man of the Reference Committee stated that the only change was in lengthy wording and that the sense of the recommendation had not been changed. The Chairman said he had signatures for the revised report. The first two paragraphs were deleted and the following substitution made:

Crippled Children Committee

Your Reference Committee recommends that all matters pertaining to fees and services be referred to the Medical Care Plans and Fees Committee.

Under the item relating to the budget for 1964-65, the Committee recommends the adoption of Dr. Bernstein's admonition that the Crippled Children Committee take a long, careful look at what the Department of Health is doing. The Reference Committee further recommends that the Crippled Children Committee study the methods of screening patients for services and make recommendations that will insure the most efficient use of the funds allocated to the Bureau of Crippled Children to be certain that services are rendered only to those who are unable to pay and for whom such services are not available through other agencies or through private insurance.

With reference to use of rehabilitation services at Leahi Hospital, your Reference Committee has doubt concerning the recommendation of the Crippled Children Committee that the Leahi Hospital Chronic Disease Unit be used for young paraplegic and quadraplegic patients. It doubts that the desired treatment goals can be achieved in the undeveloped services there and seriously doubts that the desired conservation in C.C.S. funds can be achieved by this means. Therefore, your Reference Committee recommends that further study of the advisability of sending these patients to Leahi be made by the Committee.

ACTION:

The Chairman moved adoption of this portion of the report as corrected. It was adopted.

FEDERAL MEDICAL SERVICES COMMITTEE

This Committee has been meeting approximately once a month. The attendance at these meetings from all counties has been excellent. As far as the Medicare claims are concerned, there have been no unusual difficulties with the exception that there have been some complaints as to the use of the University of Hawaii's Audiology Clinic. The Committee, however, is in the process of solving this problem.

The problem of the Medicare contract has been one of continued annoyance. The committee had hoped that they would be able to get an up-to-date relative value study so that it could contract for a more satisfactory fee schedule. However, up to the present time we have not been able to contract for a new fee schedule because we lack an up-to-date relative value study.

As Chairman of the Committee, I certainly wish to thank all the members, especially from the neighbor islands, who attend the meetings regularly.

B. Allen Richardson, M.D.

Federal Medical Services Committee

Your Reference Committee heard testimony of two physicians and recommends approval of this committee report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HOSPITAL COMMITTEE

The chairman resigned and no meetings were held.

Hospital Committee

Your Reference Committee heard testimony from four guests and recommends that the work of the Hospital Committee be assigned to the Hospital Liaison Committee back in the county medical society levels.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 5

Re: Specialized medical services in publicly operated hospitals.

Whereas, A high level of medical service cannot be maintained without adequate diagnostic procedures, and

Whereas, The services of a pathologist and a radiologist are essential to the proper diagnosis of many illnesses, and

Whereas, It is essential to the competence of medical practice and the welfare of patients that essential diagnostic services be provided by well-qualified specialists, and

Whereas, It is impossible to secure these essential services within the salary range provided under classified service, and

Whereas, The legal basis for exempting these medical specialists from classified service is at best nebulous and prevents the negotiation of contracts in the best interest of patients, hospitals, and physicians, and

Whereas, There has been a notable and striking improvement in the quality of specialized services when such are secured on a contractual fee basis, and

Whereas, Hospitals must be able to offer a quality of specialized services acceptable to the physicians or lose the service; now, therefore, be it

Resolved, That the Hawaii Medical Association request the Legislature of the State of Hawaii to amend Chapters 3 and 4, Revised Laws of Hawaii, 1955, as follows: The positions of radiologist, pathologist, and anesthesiologist shall be exempt from Civil Service status in all governmentally operated hospitals as defined under the provisions of Chapters 3 and 4, RLH 1955, as amended; and be it further

Resolved, That copies of this Resolution shall be sent to the Governor of Hawaii, the President of the Senate, the Speaker of the House, and to all members of both Senate and House.

Submitted by Hawaii County Medical Society

Resolution No. 5

Your Reference Committee heard testimony of three physicians and recommends the adoption of Resolution No. 5 with the following changes:

In Whereas No. 4, we recommend that it read as follows:

"Whereas, It is impossible to secure these essential services under existing administrative regulations which prevent the specialist from conforming to principles of practice set forth by his medical association and specialty society policies, and"

In Whereas No. 6, the Committee recommends that it read as follows:

"Whereas, There has been a notable and striking improvement in the quality of specialized services when such are secured on a fee-for-service basis, and"

ACTION:

The Chairman moved adoption of this resolution with the recommended revisions. It was adopted.

CHRONIC ILLNESS & AGING COMMITTEE

STATE COMMISSION ON AGING AND COUNTY COMMITTEE ON AGING: Act 198 of the 1963 legislature created a permanent State Commission on Aging and prepared the way for creation by law of County Committees on Aging, the priority items number one and two, of the recommendations for action of the State Interim Commission on Aging. As of March, 1964, Kauai and Honolulu were reported to have had their county committees organized.

The Budget Sesssion of the 1964 State Legislature allocated close to $16,000 for the Commission's initial year's budget. The "austerity" session of the legislature thus recognized the need for the future development of active programs for Aging in the State of Hawaii. Governor John F. Burns probably will soon announce the new State Commission on Aging.

This Committee recommends that the Hawaii Medical Association continue to support the Commission at State, County, and individual basis by its general membership.

HOME CARE PROGRAM: The Community Coordinated Home Care Program was established with the assistance of a Community Health Project Grant and began operations in April, 1961. Although based at and partially supported by St. Francis Hospital, the program offers services on a community wide basis. Services offered by the team members include: nursing care, physical therapy, occupational therapy, medical social work and diet instruction. Other ancillary services, such as laboratory, are available as needed. Referrals are made by the patient's own physician and he remains in charge of the care of his patient. Staff patients receive medical supervision through the Outpatient departments of several of the larger hospitals. A physician serving in a part-time capacity acts as a Co-Director of the program.

A Medical Advisory Committee with representation from the staffs of the three largest hospitals, Honolulu County Medical Society, and the Medical Co-Director of the program meets quarterly to review policies and make recommendations.

A total of 115 patients were referred in the 12-month period ending February 29, 1964. Of this number, 102 weer accepted and services given. In the same period 1,546 home visits were made by team members. Of the 120 patients treated during the 12 months (102 referred during period and 18 active as of March 1, 1963) 87 or 72.5% were over 60 years of age. Although Hawaii has a relatively young population as compared with the rest of the nation, these figures appear to support the belief that Home Care services are especially needed for the older age group.

Diagnoses of the patients treated during this period is given below and is typical of the type of diagnoses most commonly found on program referrals:

DIAGNOSIS	NUMBER OF PATIENTS
Cardiovascular and Pulmonary Disease	42
Central Nervous System Disease	9
Bone and Joint Disease	21
Gastrointestinal Disease	6
Renal Disease	3
Skin Disease	3
Cancer	17
Senility	17
Post Partum	1
Metabolic Disease	11
TOTAL	120

Patients with cardiovascular and pulmonary diseases have been the most frequent referrals for service while those with a diagnosis of bone and joint disease were the second largest group. Within the latter category, the most common diagnosis was fractured femur. These two categories, with that of cancer, which ranked third, indicate that services were requested chiefly for long-term patients although services were also ordered periodically for relatively short-term cases. This was especially true for short-term care following surgery in which the patient could return home sooner since services were available at home.

In the last six months, an on-call system has been set up to provide nursing service over the weekend. This arrangement was necessitated to provide for the increased number of calls for services on weekends.

Weekly rounds are made by team members at four of the local Honolulu hospitals as one method of case finding. It also serves to better acquaint personnel of the various hospitals with the services offered by the program.

Approximately 120 doctors have made referrals to the program to date. The possible total number of physicians in the community who might be expected to make referrals is approximately 350. On the discharge of any patient from the Home Care Program, a final summary form is sent to the attending physician for his evaluation of the services provided. Response has been good and the majority of replies have been favorable.

Participation in weekly conferences by referring physicians whenever possible, and by nurses from the department from which the referral was made (if patient was referred while in hospital) have served to make medical and nursing personnel more aware of the services and benefits available through the Home Care Program. This has been the most effective of any of the methods used thus far for education of medical and paramedical personnel.

This Committee recommends that HMA give strong support to this program.

VOLUNTARY INSURANCE PROGRAMS FOR THOSE OVER 65 YEARS: The HMSA Plan 65 is reported to be doing well by its administrative assistant, Albert Yuen. The plan was introduced in August, 1962. During the initial enrollment period 1,426 senior citizens were enrolled—several of them were over 90 years of age. No physical examinations were required. With some limitations, coverage began immediately. By February, 1964, the enrollment numbered 3,083. There has been no rejection regardless of medical history.

In addition to the Plan 65, HMSA has 3,750 members over 65 who are still employed and are covered in group programs. Another 3,000 members over 65 have transferred to individual plans following retirement from employment. Thus HMSA plans cover more than 10,000 people over 65 years. This is a rapid growth for this plan.

The Health Insurance Council of Hawaii introduced a bill at the 1963 and 1964 legislature to provide for enabling legislation for insurance companies to offer a selection of plans jointly administered through an association called the Western 65, similar in general to the Connecticut 65 plan. The Council believes that this is a major move in the area of providing health insurance to senior citizens at a reasonable cost.

This Committee recommends that when a similar bill is introduced by the Council at the next legislature, the HMA legislative committee strongly support its passage.

CREATION OF INDIGENT MEDICAL CARE SUBCOMMITTEE: The continued rise of the cost of indigent medical care is a recurring source of concern to those who are mandated to pay the bill.

The Committee felt that the problems inherent in the present system will become more acute in the very near future in view of: (1) DSS operating $1,000,000 in debt. (2) The Community Chest being short one-half million dollars. (3) Hospitals throughout the State are operating at a loss. The Queen's Hospital has a $400,000 loss; Waialua, Wahiawa, and other smaller hospitals cannot operate without help. This Committee felt that an investigation of the government set-up should be made.

Pursuant to the instruction of the HMA Council to create a subcommittee on indigent medical care, Dr. West appointed the subcommittee with Dr. Robert Mookini as chairman. From the initial report of this sub-committee on March 31, 1964, it was clearly evident problems relating to indigent medical care in Hawaii are multifaceted and complicated requiring intensive continued study. The

subcommittee was instructed by Dr. West to make an independent report to the House of Delegates.

IMPLEMENTATION OF KERR-MILLS (MAA) PROGRAM IN HAWAII: During the fiscal year 1962-1963, an average of 461 persons in Hawaii received help each month from DSS to meet cost of medical or hospital care. The total MAA cost for the fiscal year was $1,361,452 or 38.5% of the department's total medical expenditure for the needy.

Approximately 65% of 31,500 citizens over 65 years in Hawaii have enrolled themselves in health insurance plans and an unspecified number of government pensioners are entitled to free medical care from county government. This number is said to be comparatively small.

Mr. Among, Director of DSS, calls attention to the high cost required for chronic long-term care ($1,687 average cost per admission). The other MAA figures for 1963 fiscal year is given as follows:

1. Acute care in general hospitals
   a. Average length of hospital stay ..... 13.1 days
   b. Average cost per day (excluding cost of physician's service) $29.69
   c. Average cost per admission $386.26
2. Prolonged care in chronic illness hospitals and nursing homes
   a. Average length of stay ..... 186.3 days
   b. Average cost per patient day $9.06
   c. Average cost per admission $1,687.00

Mr. Among stated:

The aged population is susceptible to chronic illnesses more than any other age group and, although they have the least income, their medical care cost is about the highest. Prolonged hospitalization and nursing care not only drain their resources rapidly but also force other members of family, such as married children, to contribute towards the cost of his care.

The Department, like many public welfare agencies in MAA states where Kerr-Mills has been implemented, recognizes that, despite the liberal Federal financial participation, the State is unable to increase its financing for the program. Thus, the Department has taken the least undesirable course of action in keeping expenditures in line with the State's ability to pay. Our eligibility standard (means test) has been reduced to that of a welfare level. You can readily understand that such course of action is not conducive to the administration of the MAA program on the level as Congress had intended in its Kerr-Mills Act.

INDEPENDENT LIVING PROJECT, STATE DEPARTMENT OF VOCATIONAL REHABILITATION: This fine program continues its fourth year's activity as a regular state agency program. Rosemary Hayes, Honolulu county administrator, reports as follows:

During the calendar year 1963, the Independent Living Program offered rehabilitation evaluation to 94 severely disabled patients who were referred for services. During this same year a total of 116 patients received either active treatment or follow-up services. Approximately 65% of the patients served in this program were over 50 years of age and this same percentage was able to live in their own or relative's homes following treatment.

As of June 30, 1963, the special research and demonstration project for the rehabilitation of severely disabled persons to activities of daily living and self-care ended its 3 years of operation as planned. However, the services did not end because the Independent Living Program was incorporated as of July 1, 1963, into the regular program of the Division of Vocational Rehabilitation on a permanent basis. According to Federal requirements governing the regular program of the Division, eligibility for treatment must now include the existence of a potential vocational objective.

Since it is recognized that the majority of severely disabled older individuals cannot be expected to recover sufficiently to engage in outside employment a liberal interpretation is made of the term "vocational objective." It includes housewife, homemaker, babysitter, sheltered workshop activities, and home-bound industries. This last named vocational activity has been established in cooperation with Lanakila Crafts. At present there are six patients receiving training in home-bound pursuits.

To date there is no indication that either the number of referrals made or the age of referred patients has been affected significantly by the transfer of services from the Project to the regular program of the Division. The majority of patients are referred by physicians in private practice and the most frequently occurring disability is semiplegia resulting from cerebro-vascular accident.

We hope this information on program activities will be helpful to you in your report on health activities in Hawaii.

Your Committee recommends that HMA continue to support this program.

HEALTH FACILITIES PLANNING COUNCIL OF HAWAII: The little seed "Progressive Patient Care" which was first discussed at one of the CIAC-HMA monthly meetings in 1959, and subsequently discussed at the First State Conference on Aging in 1960, by 1963 has germinated into the "Health Facilities Planning Council of Hawaii" which has given us its first annual report. The council, well staffed and well financed, with a strong Board capable of doing a fine job, can develop into an effective planner for health facilities and services in Hawaii, provided responsible citizens give complete support—not only lip service—to the council.

Since health facilities and services relating to the care of the chronically ill and disabled are today's "step-child" as compared to the excellent ones flourishing for acute care, it is the wish of this Committee that this discrepancy be corrected.

This Committee recommends that the HMA give strong support to the Health Facilities Planning Council of Hawaii.

SHOYEI YAMAUCHI, M.D.

Chronic Illness & Aging Committee

Your Reference Committee heard testimony of six physicians and guests and recommends adoption of all portions of the report, except that the portion referring to legislation similar to the Western-65 plan be subject to verification concerning the advisability of pressing the H.M.A. Legislative Committee to support the passage of enabling legislation for insurance companies to offer a selection of plans jointly administered through an association similar to the Western 65.

ACTION:

The Chairman moved adoption of this portion of the report. There was a question as to why the Reference Committee voted to approve this report when they did not thoroughly understand the Western-65 Plan. It was adopted.

INDIGENT MEDICAL CARE SUBCOMMITTEE

The Medical Indigent and Indigent Care Subcommittee met on March 7, 1964. Present were Drs. Mookini, Beck, Devereux, Liu, Shepard, Vasconcellos and Walsh. It was generally agreed that there were many problems in the medical indigent care program requiring long-range study before any definite recommendations could be made. It was further suggested that a definite agenda be drawn up for future meetings and that each member of the Subcommittee be supplied pertinent subject matter prior to the meetings.

A verbal report of the Subcommittee's meeting and my personal findings concerning a variety of problems related to the indigent medical care program was presented before the Chronic Illness and Aging Committee on March 31, 1964.

It is my impression that the Department of Social Services, hereafter referred to as DSS, because of its recent budget slash, is attempting to use us as an expedient to maintain its fiscal integrity by soliciting our aid by first, instituting a medical audit; secondly, investigating the activities of government physicians; thirdly, formulating policies regarding itinerant surgical consultants.

I seriously question their motives and timing, as well as the necessity of such proposals and some of the implications thereof. Could this be a subterfuge by DSS to divert attention from their own inadequacies? How can they explain such ill-defined standards that permit activities to be considered as abuses contingent solely upon the budgetary situation. I also wonder if they have been entirely honest with all parties concerned. If so, how can they justify the Legislature's action in appropriating $3.91 per outpatient visit in spite of the general hospitals' proposal of $6.47 and the $4.93 figure recommended in a study by DSS research analyst, Mr. Jack Wakayama? In essence, this is a DSS problem, which is primarily financial, and not a question of the quality of medical care; however, staff doctors do all the work, are the backbone of the indigent medical care program, and yet have been completely ignored by DSS in the formulation of the budget. Where do we go from here?

In reference to the March 24, 1964, letter from Dr. John Peyton, Chairman of the Communicable Disease and Immunization Committee, regarding the issuing of biologicals by the Department of Health, I talked with several private doctors involved and they were under the impression that these biologicals are not issued for indigent patients alone. Off hand I would say that there is a definite overlap between the two State departments and feel that the departments involved should meet with Dr. Peyton's committee to settle this matter, including the distribution to the outpatient departments.

CONCLUSION: I recommend that this subcommittee on the Medical Indigent and Indigent Care be dissolved as I feel that all of these problems can be adequately handled by members of the major committee.

ROBERT K. MOOKINI, JR., M.D.

Indigent Medical Care Subcommittee

Your Reference Committee heard testimony from eight physicians and guests and recommends that the report be stricken from the record and that the subcommittee be reconstituted by the incoming President with members sufficiently interested to be highly active in studying and recommending solutions to the many problems which the Department of Social Services may have in conducting the Indigent Medical Care Program.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL CARE PLANS & FEES COMMITTEE

The Committee had many meetings since May, 1963. These meetings primarily concerned the state-wide fee study. The study was initiated and statisticians advise that the response was adequate. The data processing has been completed, and the processed data have been reviewed by this Committee. At the present time the reviewed data, made up of the 500 procedures included in the questionnaire, have been sent out to the various specialty groups and to representatives of the Hawaii Academy of General Practice. These groups are interpolating fees for the 1,700 unsurveyed procedures. All these data should be back to this Committee in about another six weeks at which time the final editing of the Relative Value Study will begin.

The HMSA subcommittee has been meeting regularly and a separate report is being submitted by the chairman.

A budget of $800 will be required to print finished study.

GEORGE H. MILLS, M.D.

Medical Care Plans & Fees Committee

Your Reference Committee heard testimony from eight physicians and guests and recommends adoption of this report as submitted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HMSA SUBCOMMITTEE

The Subcommittee mandated to negotiate with HMSA on proposed changes of the administrative operating procedures of HMSA as recommended by the House of Delegates submits the following interim report. Meetings with HMSA's representatives—Mr. Albert Yuen, Mr. Ralph Kiesling, and Dr. Verne Waite—were conducted on a weekly basis since September 26, 1963. HMA's representatives includes Drs. West, Batten, Tomita, and Lum.

Extensive and intensive discussions concerning the proposed changes have finally been completed. The last meeting of the group took place on February 6, 1964, at which time HMSA's representatives informed the negotiating group that the results of all these meetings would be submitted to their Executive Committee for their final adoption, approval, or rejection. There was another meeting on February 26, 1964, for further clarification. To date we have been notified that final decision on our negotiations have not been acted upon by the Executive Committee of HMSA. Your Subcommittee is, therefore, awaiting HMSA's decision and will submit a final report when this point is reached. I will be happy to furnish any further details regarding these meetings.

I wish to thank the members of this Subcommittee who have been most cooperative with their time and efforts in the deliberation of the many problems that have arisen relative to these negotiations.

CHEW MUNG LUM, M.D.

HMSA Subcommittee

Your Reference Committee recommends that the House of Delegates ask the HMSA Executive Committee to render an opinion to the State Medical Association concerning the changes in the administrative operating procedures of HMSA that were recommended by the House of Delegates of the 1963 State Medical Association meeting no later than June 1, 1964.

The Reference Committee commends this subcommittee on its work and wishes to express the hope that negotiations will soon be resumed.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NURSES LIAISON COMMITTEE

This Committee met on two occasions during the year. The first at the request of the Nurses Committee and the second on the request of the Physicians' Committee Chairman.

At the first meeting on August 23, 1963, both committees were adequately represented at which time the nurses presented: (1) problem in student nurse recruitment, and (2) a plan for a new educational program sponsored by the University in which a speed-up program could produce a basically trained nurse in two years. In the discussion the physicians were requested to assist in recruiting nursing students by advising inquiring candidates to contact the accredited nursing school supervisors or the Dean at the University, depending on the potential student's general aptitude and interest.

The other programs available such as the four-year baccalaureate program at the University plus the three-year program were freely discussed. It was generally agreed by most members of the joint committee that if and when the two-year program for nurses training was effected that in all probability a period of clinical supervision or internship for a period of six months would be needed.

Following this meeting a notice appeared in the HMA Newsletter to all physicians regarding the recommended advice to be provided to all potential nursing school candidates.

The second meeting held on March 19, 1963, was called by the Chairman to discuss, principally, joint effort in legislative matters of mutual interest to the medical and nursing professions.

Dr. John Chalmers, Chairman of the HMA Legislative Committee, was present and verbally impressed the nurses' committee with the importance of joint efforts in all matters of legislation which affect directly or indirectly both professions. It was mutually agreed by both committees after extensive discussion that such joint effort should at all times be carried out and further if legislation proposed was unilateral that each profession would request and be given assistance from the other. Both committees manifest prime interest and cooperation in this area.

Other matters of interest to both committees brought up at this meeting were: (1) A discussion of a training program for operating room technician (non-RN) which had been outlined and suggested by the American College of Surgeons and was presented by Miss Bess Owens, Supervisor of the Operating Room Section of The Queen's Hospital. Miss Owens has had some experience with this program. All appeared to agree that such a program was workable and efficient if applied properly when, and if, the need arises.

Further discussion revolved around a problem confronting the Special Duty Nurses, who have been advised that they must comply with current anti-trust legislation. It was emphasized that variations (competitive fees) could result in difficulties within this group since they could not unify and establish fees as a group, without being accused of controlling fees for service. However, the group through HNA may suggest a usual and customary fee. The HMA committee in general was surprised to learn of this problem, and agreed to help in any manner possible.

In spite of having only two meetings during the year, it is the firm belief of the Chairman that a closer liaison between physicians and their partners, the registered nurses, in care of the sick, has been established. All have agreed that our aspirations, goals, and responsibilties to our professions and our community are sufficiently common to work together more closely.

V. C. Waite, M.D.

Nurses Liaison Committee

The Chairman was present to discuss this report. Your Reference Committee recommends that the new committee continue to work with the Hawaii Nurses Association.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

The Chairman moved adoption of this corrected report as a whole. It was adopted.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 30 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AMA-ERF COMMITTEE

No official meetings were held, but correspondence was carried on with Dr. Keith E. Nesting of Honokaa, Hawaii. Under the date of September 18, 1963, a letter was circulated to all members through the executive offices, explaining the need for funds and making a plea for donations to this important project.

From reports from the National Headquarters Office in Chicago, it would appear that this effort was quite successful for to date, they report donations totaling $2,320.00 and to my knowledge numerous other donations have been made which have not received recognition in their reports.

Robert G. Benson, M.D.

AMA-ERF Committee

Your Reference Committee first considered the report of the AMA-ERF Committee. Your Reference Committee notes with satisfaction the continuing support of the AMA-ERF. Your Committee suggests that all physicians contributing to their Alma Mater funds do so through the AMA-ERF organization and that action of such contributions be sent to their respective Alma Maters.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ARRANGEMENTS COMMITTEE

Soon after its appointment the responsibilities of the Committee were divided among the members.

EXHIBITS: The Association was advised that the Princess Kaiulani Meeting House had been booked for the 1964 dates of the annual meeting. Other locations were sought. A booking was made at the new auditorium complex. Subsequently the manager advised that another group which had reserved the display area for the same dates would require space for 300 booths. This would be an undesirable conflict and would not leave enough room for the Association's booths. It was then found that the PK booking had been canceled and arrangements were made to hold the meeting in the same area that had been used in previous years. To avoid this problem in 1965, tentative bookings have been made both at the Princess Kaiulani and the new auditorium complex.

Inasmuch as there was insufficient room to permit adequate seating at the scientific sessions, a new floor plan was worked out to combine the meeting and exhibit areas. The success of this arrangement will depend on whether the admonition not to visit booths during the sessions is heeded.

All booths were sold and two exhibitors had to be turned down. After sending in their check for $100, Roche found they could not display. However, they asked that the Association keep the $100. In addition to providing free cokes for the meeting and picnic, Coca-Cola will pay $100 for their display area.

For the first time, a special section has been reserved for scientific exhibits. These will be in the same room as the voluntary health organization displays and the registration table.

BANQUET: The cost of the banquet tickets was increased from $8.50 to $10 in order to permit a change in the menu, method of arranging for the cocktails, and to provide entertainment in addition to the dance music. Roast beef instead of chicken will be served for dinner. Instead of supplying the liquor to the club and paying a corkage fee, the Club will supply the liquor and bill accordingly. The cocktail period will be for one hour only (6:30-7:30). After that time drinks may be purchased. The Club requires a guarantee of 150 people and if fewer attend, the Association will be required to make up the difference. It is hoped that there will be a good attendance even though May 2 is Club Day at Waialae.

The HCMS Woman's Auxiliary offered to take over the annual banquet and combine it with an AMA-ERF fund raising party. Although this proposal was accepted by the Council and the Committee, the Auxiliary withdrew its offer in view of the opposition of some members who felt that the annual banquet should be for doctors and should not include a fashion show or be held in a Waikiki hotel.

GOLF TOURNAMENT: Considerable difficulty was encountered in trying to book the handicappers at Waialae. The problems were worked out by the golf chairman, Dr. Felix, for this year. However, Waialae has advised that in the future they will accept no more than eight four-

somes and so in 1965 other arrangements will have to be made.

It was decided not to solicit golf prizes. An entrance fee of $3.00 will be charged and all the money that is collected will be used to buy prizes. None of the money has been allocated for pictures, and so there will be no golf movies or stills taken this year.

PICNIC: Katherine Yokoyama was again selected to cater the picnic. Coca-Cola will supply the soft drinks. Two kegs of Michelob will be purchased. No hard liquor will be served.

REGISTRATION: Since the Fireside Chats have proved so popular and the first morning of registration is always so congested, it was decided to set up a registration booth at Mabel Smyth Auditorium Wednesday evening.

The doctors of medicine who have been asked to participate in panels who are not members of the Association but who reside in Hawaii have been asked to register for the meeting.

I would strongly recommend to the House of Delegates that there be a differential in registration fees. Inasmuch as the annual meeting is a source of income, it does not appear that the registration fee of $15 can be eliminated for the members. However, I feel that the fee for nonmembers should be increased to $25.00 beginning with the next meeting.

FREDERICK B. WARSHAUER, M.D.

Arrangements Committee

Your Reference Committee next considered the report of the Arrangements Committee and commends them for the thoroughness of their report. Your Committee notes the recommendation that the Annual Meeting registration fee for nonmembers be increased to $25.00. Your Reference Committee approves the principle of this recommendation but recommends that the registration fee for nonmembers be increased to $35.00.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AWARDS COMMITTEE

On March 20, 1964, the Committee met to make a final decision on the selection of the physician to receive the Robins Award for community service. Present were Drs. Giles, Burgess, and Jim. Dr. Katsuki submitted his nominations to the chairman in writing.

The Committee was advised that only one nomination (Dr. Nils P. Larsen) was received as a result of the notice in the Newsletter. No suggestions have been received from the neighbor island members of the Committee.

Seven physicians were considered. After reviewing the activities of each nominee, the Committee decided that only one of the doctors' activities had been sufficiently directed towards nonmedical activities to warrant consideration. The doctor selected will not be advised of his selection. The Robins local representative will be advised of the selection and he will inform his company in order that the plaque and congratulatory cable can be sent. The Robins representative will also be responsible for checking into the background of the physician selected and he will make this information available to the President prior to May 1 when the award will be given.

FREDERICK L. GILES, M.D.

Awards Committee

Your Reference Committee notes with interest the report of the Awards Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BYLAWS AND PARLIAMENTARY COMMITTEE

Only one item was referred to this committee. At the September interim meeting of the House of Delegates a resolution was introduced relative to the posting of the Nominating Committee's selection.

It is felt that the intent of the Hawaii resolution could be achieved by adding the following paragraph to Chapter VIII, Section 2, and submits this wording to the House for consideration.

The report of the Nominating Committee shall be circulated to the membership at least sixty days in advance of the Annual Meeting at which it is to be acted upon. Any further nominations can be made only by petition of fifteen or more members of the Association, presented within thirty days after the Committee's report has been mailed, or thirty days before the date of the Annual Meeting, whichever date is later. No further nominations can be made except to replace a solitary nominee for office who has withdrawn.

HARRY L. ARNOLD, JR., M.D.

Bylaws and Parliamentary Committee

Your Reference Committee next considered the Bylaws and Parliamentary Committee report. Your Committee noted that the report submitted a change in the Bylaws, Chapter 8 Section 2, relating to action taken by the House of Delegates at the interim meeting of September, 1963. Your Reference Committee submits the following modification to the report of the Bylaws and Parliamentary Committee. The recommended change should now read "The report of the Nominating Committee shall be circulated to the membership at least 30 days in advance of the Annual Meeting at which it is to be acted upon." The remainder of the recommendation of the Bylaws and Parliamentary Committee was not accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

The opinion was expressed that the Nominating Committee should be nominated from the House of Delegates. It was also felt it would be more democratic this way and no one group would be in complete control.

CONVENTION & SEMINAR COMMITTEE

This Committee was activated by Dr. Frederick Giles in February, 1963, the reason that prompted the need of such a committee was the increasing number of requests from mainland medical organizations to have medical meetings in Hawaii.

After the initial meeting of the committee and subsequent instructions from the Council of the Hawaii Medical Association, the functions of the committee has expanded to include the following:

1. Assist medical organizations who are interested in having conventions or postconvention meetings in Hawaii.
2. Sponsor postconvention seminars to coincide with large medical conventions on the West Coast.
3. Serve as a "clearing house" for all postgraduate lectures, seminars and meetings of medical interest in Hawaii.
4. Investigate possibilities of arranging charter or group flights to such countries as Japan, Australia, etc.

To date we have worked with several groups meeting in Hawaii and are working on others for the future. News releases of this establishment of the Committee were sent to the *AMA News*. Similar notices were sent to several organizations planning conventions on the West Coast.

The Academy of Psychosomatic Medicine planned a postconvention tour for October, 1963. Much time was

spent in communications and planning but this had to be cancelled because of lack of interest from the members of the Academy.

A postconvention tour was initiated with the American Electroencephalographic Society but this also fell through because of insufficient time.

A postconvention tour was held for the National Medical Association in August, 1963. This gave our committee an opportunity to gain valuable experience but without any income to the Hawaii Medical Association.

Plans to assist the International Society for Research on the Reticuloendothelial System were dropped because they expected to be subsidized by Hawaii businessmen.

Planning for the Second Hawaii Medical Seminar in June, 1964, (after the AMA meeting in San Francisco) is proceeding quite satisfactorily and we are hoping for a successful culmination of this committee's activities.

Initial communications have been made with several airlines and it seems that a very reasonable tour can be arranged on a group basis. Nearly all airlines have discouraged tours on a charter basis. The incoming committee should proceed with the idea of having a HMA medical group tour to the Orient in 1965 or 1966.

Because of laxity and a recent convention, your Chairman has been unable to communicate individually with all members of the committee before submitting this report. Therefore, the following recommendations are that only of the Chairman. Also, I would like to take this opportunity to apologize for the lateness of this report.

1. It is recommended that this Committee be made a standing committee of the Hawaii Medical Association and that its functions be continued as listed in the early part of this report.
2. It is also recommended that the Council consider changing the composition of the membership of the committee. I feel that the work of the Chairman could be more easily accomplished if it would consist of members who are involved with preparation and planning of educational and postgraduate programs. I would like to suggest that the committee be composed of the chairman of the Scientific Program Committee of the HMA, program chairman of the HCMS, medical education directors of the active hospitals in Honolulu, and the chairman of all program committees of the specialty societies organized in Honolulu.

JOHN M. FELIX, M.D.

Convention and Seminar Committee

Your Reference Committee notes with interest the report of the Convention and Seminar Committee and accepts the report in toto. Your Reference Committee notes that the Convention and Seminar Committee is already a standing committee of the Hawaii Medical Association. Your Reference Committee recommends that the incoming President consider the recommendation referring to its composition.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HONOLULU COUNTY MEDICAL SOCIETY

The Honolulu County Medical Society held nine regular meetings during the year of 1963. No meeting was held in May because of conflict with the State Association annual meeting and no meetings were held during July or August because of summer vacation. The Board of Governors met monthly throughout the year.

The Society was faced with the problem of changing personnel during the year but this was resolved and the office is now on an efficient functional basis.

Programs for the monthly membership meetings were diverse. Both socio-economic as well as medical topics were presented to the membership. The balance of such type program seemed to be highly acceptable as the average attendance during the year was measurably greater.

Scientific sessions were specially programmed by the Postgraduate Committee.

At the end of the year, the Society Bylaws were under study and it is anticipated that early in 1964, revisions will be accomplished to more closely correlate the Society Bylaws with those of HMA and the AMA.

The working relationships between HMSA and the County Society were subjected to considerable study and effort. It appears that the relationship with HMSA and the communications between the organizations are much improved and will continue to improve.

The subsidiary of the Society, the Bureau of Medical Economics, has continued to improve its position. The Foundation for Medical Care is showing signs of activity and it is hoped that the coming year will see this stepped up to a full-fledged function of the Society.

HAWAII COUNTY MEDICAL SOCIETY

PRESIDENTS—R. P. Henderson—May to December, 1963; R. P. Wipperman— January to April, 1964.

HIGHLIGHTS: (1) $2,000.00 scholarship to Henry Minette to Tulane for Public Health. (2) Annual Christmas Party at the Hilo Country Club. (3) Two scholarships to Wilfred Y. Fujimoto and Thomas C. Eshelman (One is a Freshman and the other Junior in a medical school).

EVENTS: (1) Movie on Management of Hepatitis and Portal Hypertension by A. H. Robbins Co. (2) Movie—C.P.C. on Congenital Defects.

SPEAKERS: (1) James P. Cooney, Vice-President of Medical Affairs of the American Cancer Society. Subject: *Viruses in Cancer.* (2) Dr. William Beierwaltes, Professor of Internal Medicine and Coordinator of Nuclear Medicine at University of Michigan Medical Center. Subject: *Radioisotopes in the Management of Renal Diseases, Hypertension and Heart Disease.* (3) Dr. Verne Waite on *Diverticulitis of the Cecum.* (4) Dr. M. Eugene Lahey, Chairman of the Dept. of Pediatrics of Utah University Medical School. Subject: *The Management of Iron Deficiency Anemia.* (5) Dr. Rodney West, Obstetrician, Straub Clinic, and President of HMA. Subject: *Renograms and Its Usefulness, also the OB and Gyn Practice.* (6) Dr. Lowell G. Rance (sp?) of Stanford University. Subject: *Pyelonephritis.* (7) Dr. Andrew Ivy, Chairman of the Public Relations Committee of HMA. Subject: *Work and Scope of Public Relations Committee.* (8) Dr. Waltman Walters, Professor of Surgery, Mayo Clinic. Subject: *Pancreatitis and also made brief comments on gastric CA.* (9) Dr. Henry Harkins. Subject: *Surgical Treatment of Peptic Ulcer.* (10) Dr. Virginia Apgar of the National Foundation. Subject: *Diagnosis of Hidden Congenital Defects.* (11) Dr. Samuel Allison, Dermatologist. Subject: *Common Dermatitides.* (12) Dr. James Raleigh of New York City of American Thoracic Society. Subject: *Smoking and Its Relation to CA and Respiratory Diseases.*

KAUAI COUNTY MEDICAL SOCIETY

The year 1963 closed on the theme of education and service to the Community. It is said, "that the purpose of education is to stimulate and guide students in their self-development." This statement was proved by the wide range of speakers and the numerous subjects covered this year with subjects ranging from Cancer to Public Relations. Among a few of the distinguished speakers were Dr. Emerson Day, who spoke on the Diagnosis and Prevention of Cancer; Dr. Abraham Cockett, distinguished brother of one of the Society's members, who spoke on Renal Hypertension; and Dr. Virginia Apgar and Dr. Donald Char on Birth Defects. Non-medical topics were presented by Mr. Aubrey Gates, Field Service Director of A.M.A.; Dr. Andrew C. Ivy Jr., who spoke on Public Relations and the H.M.A.; and reports from the President of H.M.A., Dr. Rodney West, and the incoming president on the plans for the forthcoming

convention. As an adjunct to this quest for education the Society received money for the purchase of books from the Board of Medical Examiners and the Cancer Society.

As a service to the Community of Kauai, the Society supported numerous projects varied in character. It approved and supported the establishment of the Convulsive Disorder Clinic. Members participated in the Diabetic Detection Program, which was under the co-chairmanship of Doctors Kim and Wade, and at present a follow-up program is in operation. The State Public Health Nurses have established a Registry for Diabetic Cases, which is based on known cases plus those cases detected through the Survey, they will endeavor to aid these people in the development of good diet habits and good hygiene.

In its effort to perpetuate the field of medicine of Kauai, the Society obtained literature on medical schools. Members acted as advisors to those questing information. Dr. Boyden was named as a member to the Hawaii Medical Association's Medical Education Committee and the Careers Committee. In the latter role he interviewed five students from the local high schools and made arrangements for their participation in Career Day in Honolulu.

As all know, the area of mental health has taken on new importance. Drs. Miyashiro and Goodhue were named to serve on the Kauai County Steering Committee on Planning for Mental Health.

Members of the Society met with the Kauai Senators and Representatives at a dinner meeting prior to the opening of the State Legislature and reviewed with them several of the various items affecting medicine such as amendment of the licensing law to permit the issuance of temporary licenses to doctors in areas where they are needed, as well as other social legislation needed in the State.

As this was the twenty-fifth Anniversary Year of the G. N. Wilcox Memorial Hospital, several members of the Kauai County Medical Society were honored for their part in the development of the hospital; they were Doctors Wade, Brennecke, Boyden, Kuhns, and Wallis.

In conclusion, the Society has joined with other island Societies of the Hawaii Medical Association to amend Paragraph 5 of the H.M.S.A Physicians' Participating Agreement.

As a member of the Association it has participated in conventions, council and committee meetings to help forward the word of the Association. In this area, there might be said, there have been some difference of opinions, but not difference of principles. As said by Jefferson in one of his speeches of a candidate," can he be trusted with the governing of himself, can he be trusted with the governing of others, or . . . let history answer this question."

In December of 1963, new officers were elected and took office immediately. New committees have been appointed and are functioning. The Society will continue this year of 1964 its efforts to keep pace with the ever-changing times and to offer its continued service to the community of Kauai.

MAUI*

During the year the Maui County Medical Society coasted along its tranquil way under the leadership of Dr. William E. Iaconetti. During the greater part of the year the secretaryship was carried on by Dr. Kenneth Haling who acted in the absence of Dr. James F. Fleming, who was doing a stint of missionary medicine in India and Africa. On his return to Maui in November, Dr. Fleming was awarded the dubious reward of being elected Society President for 1964.

During the year Drs. Watt, Sowers, and Van Loon were dropped from the Society rolls because they had left Maui. Dr. Joyeuse was accepted into membership.

In May, Dr. William H. Beierwaltes gave the Maui members a good discussion on *Radioisotope Diagnosis and Therapy of Hyperthyroidism and Radiosensitive Thyroid Cancer.*

In September, Dr. Rodney West brought the membership up to date on the status of the Hawaii Medical Association and Mr. Aubrey Gates explained the importance of good public relations.

There were a couple of scientific meetings interspersed among the routine business meetings. We will be looking forward to another tranquil year in 1964.

Annual Reports of the County Medical Societies

Your Reference Committee reviewed the reports of the above named County Societies and wishes to recognize the continuing participation of its member societies in matters of socio-economic and scientific interest.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL JOURNAL

For the fourth successive year, fewer advertisements have made us reduce the size of your HAWAII MEDICAL JOURNAL; the 1963-64 average was only 86 pages, six less than last year (the nonintegral multiple of four reflects insert advertisements). The tabulation shows the average page distribution for the past five years:

	1959-60	1960-61	1961-62	1962-63	1963-64
Scientific	17	19	17	19	18½
Features	24	17	24	23	27
Technologists	2	2	2	2	2
Advertising	80	60	53	48	38½
Total	130	104	100	92	86

The increased space for "Features" reflects in part the use of 50 pages (an average of over 8 per issue) to report Hawaii Medical Association transactions and Council meeting minutes. It also includes 49 signed book reviews written by members of the Association and 99 unsigned capsule book reviews written by the Editor; the books, the total purchase cost of which would have been $1,319, were donated to the Hawaii Medical Library as they were received. Also donated to the Library were exchange subscriptions to 175 medical journals, representing a saving to the Library, if it were to buy them all, of approximately $800, and a cost to us, at the going subscription rate, of $1,050. The real cost to us, since additional copies of the JOURNAL over any given number ordered cost far less than the first few hundred, is considerably less.

The JOURNAL now goes to 175 paying subscribers, 627 dues-paying member physicians, and 83 medical technologists. Free JOURNALS are sent to 53 advertisers and their agencies, 14 publishers, and 34 miscellaneous recipients.

Dr. Fred Reppun's feature page for the Hawaii Academy of General Practice has been continued in every issue; so have "In Memoriam," for which Mrs. Robert Katsuki has supplied the copy for 49 instalments to date, and "Reports & Snorts," a page of miscellany used, hopefully, to draw readers into the advertising page area of the magazine. We hope you haven't been missing it. "Reports on Poisoning" has not been revived, for lack of interest. A Bureau of Medical Economics page has been added this year, and a revival of Maternal and Perinatal Deaths is anticipated.

Dr. Doris Jasinski has continued to work effectively in the capacity of Assistant Editor; Dr. Toru Nishigaya resigned as News Editor during the year and was replaced by Dr. Casimer Jasinski, beginning in the January-February issue this year—and ending in the July-August issue. Dr. Winfred Lee has agreed to assume the job of Book Review Editor, a position filled twice unsuccessfully, in the past.

During the year the editorial policy of the JOURNAL was questioned orally by the Council, but no action was taken.

* Received after the annual meeting.

To avoid misunderstandings, it is our view that the purpose of the President's Page is to permit the President of the HMA to present whatever message he may have, whether it represents policy already adopted, or the reverse, or neither; and regardless—good taste, punctuation, and syntax excepted—of whether the Editor approves of it or not. The Editor should be expected to provide editorial comment from time to time on various questions affecting the practice of medicine in the state, or medical public relations; such comments will usually follow, but may occasionally lead, current medical opinion. They will not, however, unless in the most extraordinary circumstances, run counter to an official Medical Association position. Signed editorials, of course, reflect the writer's opinion only.

The Council seems a little too large and unwieldy a body to serve effectively as a Publications Committee; on the other hand, it has proved difficult in the past to find members sufficiently interested to form an effective committee for this purpose. Perhaps the Past President, President, President-elect and Editor could form such a committee. It is suggested that a trial of this sort be made.

In the interest of economy, it is recommended that HMA committee reports be condensed for publication in the JOURNAL and limited largely to committee recommendations for action.

Finally, it is recommended that you approve the continued publication of the JOURNAL on the same basis as last year.

HARRY L. ARNOLD, JR., M.D.

Hawaii Medical Journal

Your Reference Committee noted with interest the scholarly report of the Editor on behalf of the HAWAII MEDICAL JOURNAL and commends him upon his continuing industry in the JOURNAL of which all members of the Association can be proud. Your Committee concurs in the recommendation that the Hawaii Medical Association Committee reports be as brief as possible and they should be confined primarily to recommendations for action. This condensation should preferably be done by the committee chairman. Your Committee also recommends the approval of the continued publication of the JOURNAL on the same basis as last year.

Your Committee learned that in the past, appointment of the Editor had been done annually by the House of Delegates but in recent years this has not been done. Your Reference Committee recommends that the Editor of the HAWAII MEDICAL JOURNAL be appointed annually by the Council.

Your Reference Committee notes with interest the appointment of a Publications Committee and heartily endorses this action. Your Reference Committee recommends that the Publications Committee be composed of the Past President, President, President-Elect, Secretary, Treasurer, and the Editor of the JOURNAL as a nonvoting member. Your Reference Committee takes pleasure in recommending that a letter of appreciation be sent by the Secretary of the Association to Mrs. Robert Katsuki for long service to the JOURNAL for the feature "In Memoriam."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 2

Re: Drugs

WHEREAS, The House of Delegates of the American Medical Association at its last annual meeting approved physicians' dispensing of drugs and physician ownership of pharmacies as long as there is no exploitation of the patient, and

WHEREAS, We believe that it is an inherent and inalienable right of the physician to dispense drugs in the course of the practice of his profession, and

WHEREAS, It is an inherent and inalienable right as a free American to invest with reasonable expectation of profit, if exploitation of the patient is not the result; therefore, be it

Resolved, By the Delegates of the Hawaii Medical Association at its annual meeting that the Delegate and Alternate Delegate from Hawaii to the American Medical Association be instructed to endorse the previous stand of the House of Delegates of the American Medical Association and to make all efforts to insure that these rights of physicians are not abrogated.

Submitted by JOHN F. CHALMERS, M.D.

Resolution No. 2

Your Reference Committee heard all discussants supporting the intent of the Resolution; however, several speakers recommended a minor modification of this proposed statement: "WHEREAS, It is an inherent and inalienable right as a free American to invest with reasonable expectation of profit, if exploitation of the patient is not the result; therefore, be it." Your Reference Committee recommends the adoption of this Resolution with the substitution of the following to replace the third paragraph of the original resolution: "WHEREAS, It is an inherent and inalienable right as a free American to invest in any legal private enterprise which does not violate the code of ethics of the American Medical Association; therefore be it."

ACTION:

The Chairman moved adoption of this resolution as revised. It was adopted.

RESOLUTION NO. 6

Re: Ambulances.

WHEREAS, It has repeatedly been demonstrated in many mainland cities that more lives are lost and others jeopardized through wanton disregard for traffic safety rules by ambulance drivers than have been saved by the use of sirens, speeding, and ignoring traffic regulations, and

WHEREAS, The streets and highways of Hawaii are more congested by traffic each succeeding year; therefore be it

Resolved, That the Hawaii Medical Association recommend to appropriate Government officials that the use of sirens by ambulances be discontinued, and that ambulance drivers be required to obey all traffic rules and regulations.

Submitted by FREDERICK B. WARSHAUER, M.D.
and P. H. LILJESTRAND, M.D.

Resolution No. 6

Your Reference Committee approves without change this Resolution.

ACTION:

The Chairman moved adoption of this resolution. It was adopted.

RESOLUTION NO. 8

Re: County Presidents as Council Members

WHEREAS, The president of each component county medical society of the Hawaii Medical Association is regularly invited to attend the Council meetings of the Association, and

WHEREAS, The presidents of the county medical societies are vice presidents of the Hawaii Medical Association, and

WHEREAS, The members of each county medical as-

sociation look to their elected president for information and leadership: therefore be it

Resolved, That the structure of the Council of the Hawaii Medical Association be changed to include all officers of the Hawaii Medical Association and that each county medical society president be made a full member of this Council.

Submitted by the HAWAII COUNTY MEDICAL SOCIETY

Resolution No. 8

Your Reference Committee gave careful consideration to Resolution No. 8 but did not concur.

ACTION:

The Chairman recommended that this resolution not be adopted. Dr. Wipperman protested the Committee's recommendation. He felt that the presidents of each county should have a vote in the Council. It was noted that the reason for submitting this resolution was to enable the county presidents to have greater knowledge of what transpires at the Council meetings; sometimes the presidents of the county societies do not get full information of all transactions. It was not adopted.

LEGISLATIVE COMMITTEE

In submitting its final report, the Committee has several recommendations to make. A supplementary report giving in detail the action of the Legislature on bills and items on the budget in which we were specifically interested will be included in Mr. Honda's report.

Since the past session was largely devoted to state finances very little urgency legislation was actually considered by the Legislature and most, if not all, of the bills introduced which failed to pass will be introduced in the General Session next year. Since we know what all of these items are, our recommendation is that the Legislative Committee meet at least monthly beginning shortly after the annual meeting to prepare for the next session even though it will be ten months away.

Special comment should be made on the proposed revision of the Medical Practice Act, fully realizing that there are wide differences of opinion, particularly with reference to the one-year residence clause and to temporary or probationary licensure. Your Committee urges the President of the Association to appoint a small committee (representing divergent views) to meet with representatives of the Attorney General's office, the Health Department, and the Board of Medical Examiners in an attempt to work out a solution to the perplexing problems in the Medical Practice Act. It is our feeling that it is better to work this problem out prior to the next session of the Legislature, and with some voice in the revision, rather than to have it rammed down our throats. It is far better to ride the horse than to be dragged along behind it!

This Committee is disappointed at the stand which the Legislature took in voting approval of the Podiatry Prescription Act. Having first defeated the measure, the House voted to reconsider it, and finally passed it. Our sole chance of limiting the type of drugs which podiatrists may order now lies with the regulations which the Health Department will impose. We will have an opportunity to make our views known at Public Hearings on the matter.

One item which bears re-emphasis was the statement by Senator Yano that he looked with considerable disfavor upon the attempts of individual physicians to kill specific measures by contacting their "buddies" in the Legislature before bills had had an adequate hearing before the committees to which they had been assigned. This constitutes "government by cronies" rather than the democratic process where all sides are given an adequate hearing.

Additional pressure will be brought by pharmacists in the coming session of the Legislature to restrict physician and hospital dispensing of drugs, as well as the attempt to force the use of generic names and itemizing ingredients on prescription drug labels.

Your Committee invited the Woman's Auxiliary to send a representative to its meetings and we now have a request by the Hawaii Nurses' Association to "exchange" members so that we may keep each other informed and be able to present a united front in matters affecting both our groups. It is recommended that this be approved.

The 1965 session of the Legislature will bring with it many problems. It is our recommendation that we make a sincere attempt to be "for" more legislation (or to see that legislation is introduced which we can support) rather than to always be, or put in the position of appearing to be, in opposition to everything. We spend thousands of dollars for public relations to try to improve our image before the public and then by a few ill-advised and thoughtless moves completely erase the image.

A telephone poll of the committee members was made relative to employing a paid lobbyist. Diverse opinions were expressed.

The new committee respectfully requests the same budget as last year except that due to the longer session the allotment for clerical help and entertainment should be doubled and the counsel's fee increased to $7,000.

JOHN F. CHALMERS, M.D.

Legislative Committee

This report was the subject of extensive discussion by those appearing before your Committee. After careful consideration of all of the views presented, your Reference Committee approves the recommendation that the Legislative Committee meet monthly, and further approves the recommendation of establishing liaison with the Woman's Auxiliary, Hawaii Nurses Association, and other interested groups. Your Reference Committee notes that the Legislative Committee has urged the President to appoint a small committee to work on the problems of the Medical Practice Act. Your Reference Committee heartily endorses this request.

After careful consideration, your Reference Committee strongly recommends the continuation of the services of the Legislative Counsel. We urge that negotiations be carried out with the thought that the requested fee of $7,000. might be reduced. Your Reference Committee strongly urges more active participation in legislative matters by the members of the Hawaii Medical Association. Your reference committee recommends approval of the new committee's budgetary request with the hope that the full allocation will not be used.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COUNSEL

The Second State Legislature, Budget Session of 1964, was a fairly productive one, considering the shortness of the period of the session. It passed more than double the number of bills passed in the 1962 Session.

Medically related bills that passed were as follows:

SB-33: Allows the gathering of information for mental illness studies and giving protection to those imparting information (comparable to "Goto" bill of 1963 Session).

SB-34: Amends the Hawaii laws to insure availability of Federal funds for mental retardation program and for hospitals and other medical facilities.

SB-35: Authorizes podiatrists to prescribe non-narcotic drugs. In this connection, it is understood that the State Health Department will regulate the podiatrists' prescription of drugs to problems connected with the foot.

SB-302: Provides for $873,000+ to cover deficiency in the appropriation for medical care of indigents in the Department of Social Services.

SB-275: Allows for increase or decrease of fees (registration, application, etc.) up to 50% with the approval of the appropriate board or commission and the approval

of the Governor. Present doctors' application fee is $50.00 and annual renewal fee is $5.00.

HB-488: Amends medical care provision for pensioners by removing the provision regarding the method of determining dependency.

The other bill of importance to HMA members is HB-2, the operating budget of the State of Hawaii. Generally speaking, the current level of services was maintained in areas such as the U.H. Student Health Program, D.S.S., and like programs.

Adopted by both houses was Senate Concurrent Resolution No. 7, relating to the U.H. Bio-medical Sciences Program.

An evaluation of the session concluded would seem to show that there were numerous non-money items that were introduced and considered; that the budget-making process is tough and often complicated; that the HMA, in the over-all legislative picture did not fare badly as far as results are concerned.

There were problems of some importance that cropped up during the course of the session, the most serious of which was SB-32, dealing with the temporary licenses for the practice of medicine. There seemed to be a marked division of opinion on this particular bill within the medical profession. Certain members of the Senate Health Committee expressed much interest and concern regarding this bill, and, although a "compromise" arrangement was worked out, it was strongly suggested that it was temporary only.

The following subject areas merit your consideration even to the extent of proposing, if not reviewing legislative proposals. (1) the medical practice act, which should be reviewed for possible changes or improvement; (2) continued study and improvement of the working relationship between hospitals and doctors and the latters' privilege to practice medicine in hospitals; (3) legislation requiring labeling of drugs by generic names, showing of ingredients contained in prescribed drugs, etc.; in connection with drugs, it would be desirable that the HMA actively seek the pharmacists and pharmaceutical firms to work together on any foreseeable problems; (4) there may be a re-introduction of the bill to certify or to license psychologists and the HMA might work closely with interested groups to see that the HMA's suggestions are incorporated in any legislative proposal.

During the immediate past session, a series of bills regarding the taking, detention and custody of mentally ill persons were introduced. The Mental Health Association and the psychiatrists were the direct proponents of the bills. If the HMA wishes to play a part in advocating the proposals contained in these bills, it may be well to work with re-drafting of the bills to meet some of the objections encountered in the legislature.

The foregoing constitutes a report of the '64 Budget Session of the Legislature. If your organization wishes to discuss any part of this report or any other matter connected with legislation, I shall try to accommodate you in any way I can.

EDWIN H. HONDA, LL.B.

Legislative Counsel

Your Reference Committee carefully surveyed the report of the Legislative Counsel and strongly recommends that each member of the Association acquaint himself with the contents.

Mr. President, I move the adoption of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BOARD OF MANAGEMENT OF THE MABEL SMYTH BUILDING

The 1963 members of the Board of Management representing the Hawaii Medical Association were reappointed. Representing the Hawaii Nurses' Association are Miss Alison MacBride (re-appointed), and Mrs. Wilma Amalu replacing Mrs. Alex Walsh in January, 1964. The Queen's Hospital is represented by Mr. A. J. Hebert.

In March, 1963, the Board had a letter from V. Thomas Rice, attorney for the Honolulu County Medical Society, making an offer regarding a lease. The Board of Management accepted the offer if Queen's could obtain a court order modifying the lease clause. June, 1963, Queen's went to court regarding the sublet clause. Modification was approved.

Radio Page equipment was ordered in June for the Nurses and Physicians' Exchange. It did not arrive until December. The exchange has 91 members using Radio Page. Two-thirds of this number were already members of the Exchange. More new are needed in order to break even. Most of the members are satisfied and enjoy using the new equipment. A few do not.

The Library moved into their new building in October. BME moved to the vacated space in November. Air-conditioning equipment was installed for the 2d floor in January. HMA moved to their new quarters in February. HCMS moved upstairs, March 20. Hawaii Nurses' Association moved downstairs to the first floor.

Renovations costing $10,000.00 were done. A rate of 41¢ per square foot was established for all rental space. The second floor has the benefit of air-conditioning. The rental also covers the use of the auditorium, lounge, and lanai, equipment, lights, maid and janitor service at no further cost.

Honolulu County requested a meeting with the Hawaii Medical Association and Mabel Smyth Building's Finance Committee to discuss plans for expansion. The meeting was held March 5, 1964. At this meeting, Dr. West asked how great was the need for more space by the Honolulu County Medical Society. Dr. Richardson said that they were quite comfortable and would not need any more space for the next ten years. Dr. West made a motion that this be referred back to the Board of Governors to determine whether or not anything further should be done. Dr. Mills seconded the motion and it was passed. This action is hard to understand in view of the letters we have from the Honolulu County Medical Society and their attorney, indicating that they would be bargaining in good faith. All arrangements with Mabel Smyth Building for occupancy of the library space stated that it was to be on a temporary basis.

Mabel Smyth Building has been put to considerable expense and is still in the same state it was before, no space, no extra conference rooms, and no place for expansion. A copy of the Mabel Smyth budget for the fiscal year June 1963-1964 has been submitted to the HMA. Please note that there will be extra expenses and less income, these are noted on a separate slip. Board meeting minutes and the auditor's report have also been submitted to the HMA and are available for perusal.

H. Q. PANG, M.D.

Board of Management of the Mabel Smyth Building

Your Reference Committee reviewed with some concern this report. Your Reference Committee recommends that the Hawaii Medical Association request a meeting of the parties concerned in the management of the Mabel Smyth Building with the intent of resolving the differences that now exist. Your Reference Committee recommends that all physicians give serious consideration to utilizing the modernized equipment of the Physicians' Exchange.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT'S REPORT

I wish to take this opportunity to express my appreciation to all who have given of their time, talent, and advice during the past year. Such help has made it possible for

the continuation and for the success which has been achieved with the entire program of the HMA for 1963-64.

Noticeable among our successes has been the excellent professional public relations program which has been sparked by Dr. Andrew C. Ivy, Jr., and engineered by Mr. Hugh Lytle. We are making excellent headway here via our press, radio, and TV programs, but we still know that there is much to be done in the way of scope and increased efficiency of operations. I am certain that the coming year will show further advances.

Our highly successful and satisfactory Careers Day under the guidance of Drs. Sau Ki Wong and John Stephenson shows what can be done in acquainting our high school students with a career in medicine. This has certainly proved itself to be a desired and needed annual endeavor of the HMA. The inclusion of Kauai this year and possibly Maui and Hawaii next year is a step in the right direction. Medical and paramedical fields were well represented at the annual Careers Day held at the University of Hawaii and for this we owe much thanks to Dr. Doris Jasinski.

The Medical Care Plans and Fees Committee, under the chairmanship of Dr. George H. Mills, has probably put in more time as a group than has any other committee of the Association for many years, and we should soon see the results of our Fee Survey and some revisions of the operating procedures of the HMSA.

Other Committee activities have probably not been so dramatic, but are equally needed and praiseworthy. Two new Committees—Medical Education and Automotive Safety—and a subcommittee on Indigent Medical Care, increased the total number of committees in the HMA to 35. Appointing proper and interested members to these committees is a big task in itself, and I want to congratulate our President-Elect on the fact that the committees for next year have already been appointed and begun their activities for 1964-65.

During the year I made five visits to the neighbor island county societies. My chief purpose was to enhance communications between all of the component societies, and to have better coordinated activities. I felt that these visits were very worth while and should be continued by subsequent presidents.

The work of the HMA is definitely becoming more complicated and time consuming and has therefore over the past several years placed a greater and greater load on the President and President-Elect. This was somewhat eased this year by several get-togethers of the officers, the calling of four Council meetings, and an interim meeting of the House of Delegates. In spite of this almost doubling of the previous activities of these groups, the time has probably arrived when regular meetings of the officers are necessary in order to carry on the work of the Association in a more orderly and efficient manner. I would certainly encourage this and at least four Council meetings a year.

During the year there was also a reorganization of the executive staff and a better delineation of the lines of authority. With this and the added help, we now seem to have a more efficient operation, and with our new quarters we should be able to put out a greater volume of work in a smoother manner.

Again I wish to thank our hard-working executive staff under the direction of Miss McCaslin, the officers, the Council, the committee chairmen, committee members, and others for their help and their tolerance during the past year. To the new leaders and workers for next year, I want to express my sincerest hope for further progress and much success. Aloha.

RODNEY T. WEST, M.D.

President's Report

Your Reference Committee reviewed the President's Report in which he masterfully summarized the highlights of his year's tenure. Your Reference Committee wishes to commend the President on a job well done.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC PROGRAM

The Committee met on numerous occasions to plan for the scientific portion of the annual meeting.

Two papers and seven panels were decided upon and each panel assigned a coordinator. Financial assistance was received from the E. R. Squibb & Sons through the auspices of the American Therapeutic Association. The Hawaii Heart Association is sponsoring Dr. Irvine H. Page and the Hawaii State Psychiatric Training Program is sponsoring Dr. William F. Sheeley. In addition Lederle Laboratories offered financial support which was greatly appreciated. It was suggested that in lieu of this they consider underwriting the expense of the scientific portion of the 1965 annual meeting.

Dr. Robert P. C. Ho, who will chair the committee for 1964-65, has attended the past few meetings of the outgoing committee. He will follow through with the financial arrangements for next year.

The Committee originally planned to start the scientific session on Wednesday evening with fireside chats to be called Ka Halawai O Na Kauka since some of the sponsors, both present and potential, do not feel the scientific portion of the annual meeting is sufficiently long to warrant the expense of sending out speakers. However, the Committee found that the Hawaii Thoracic Society plans to continue this Wednesday evening program on an annual basis. Since this year's theme, cardiovascular disease, worked in very well with their format, all six of the mainland speakers have been included in their discussion groups.

This year for the first time there will be a number of outstanding scientific exhibits by members of the Association and various health agencies. These exhibits have been limited to cardiovascular subjects.

FRED I. GILBERT, JR., M.D.

Scientific Program Committee

Your Reference Committee next considered the report of the Scientific Program Committee and takes note that in order to acquire the best speakers, arrangements need to be made at least two years ahead of the proposed meeting.

Your Reference Committee strongly recommends that in the future the Scientific Program Committee work closely with the Convention and Seminar Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SECRETARY'S REPORT

The total active membership of the Association, as of December 31, 1963, was 660, an increase of 37 over December 31, 1962. The inactive members, reported through only one county, numbered 6. This reflects considerable improvement in membership reporting. As of December 31, 1962, 25 inactive members were reported. The status of several members included in the Association's list of active members as dues-waived due to postgraduate training was not resolved prior to the end of the calendar year. However, with the newly revised bylaws of the Honolulu County Medical Society this will be corrected and no future problem is anticipated.

Of the 660 active members, 46 were granted dues waiver, an increase of 5 over last year.

The total number of licenses issued to physicians to practice medicine in Hawaii as of December 31, 1963, was 1,059, an increase of 62 over last year. Of these, 293, or an increase of 14 over the previous year, were nonresidents.

	ACTIVE DUES PAYING	ACTIVE DUES WAIVED	TOTAL
Hawaii	45	10	55
Honolulu	527	33	560
Kauai	10	2	12
Maui	31	1	32
TOTAL	613	46	659

Nine members who died during 1963: Drs. Gardner Black, Eijiro Nishijima, Sumner Price, Thomas Tamura, C. W. Trexler, Joseph Palma, Harold McKeen, Donald Wright, and Young P. Kang.

There is a discrepancy of one member in the HMA and Honolulu County rosters. Dr. E. Wonsik You was dropped for nonpayment of Legislative Assessment after the Council voted not to accept his request for waiver because of financial inability to pay. The County was advised of this action but failed to act upon it. The AMA was advised of this action and he was accordingly dropped from their roster.

Since the last annual meeting there have been four Council meetings and one interim House of Delegates meeting. The interim meeting of the House of Delegates was devoted solely to budgetary and fiscal matters. The following is a summary of some of the more important actions taken by the Council since the last annual meeting:

At the July 24 meeting it was decided to await the AMA plan rather than pursue statewide plans for setting up an investment program for members. It was ruled that funds cannot be transferred from the Physicians' Benevolent Fund for purposes other than those set forth in the enabling action that formed the Fund. Authorization was made for a letter to be sent to labor unions, the Employers Council, various Chambers of Commerce, etc., offering the Association's services in evaluating health insurance policies. Only one reply was received, from Mrs. McElrath, and nothing has developed on her tentative request. Group malpractice insurance was again discussed but to date nothing has been made available for presentation to the Council.

At the November 20 meeting interim reports from 20 committees were reviewed. Authorization was given the Convention and Seminar Committee to pursue plans for a chartered flight to the Orient for HMA members. The Chronic Illness and Aging Committee was requested to form a subcommittee to investigate indigent medical care and the government physician set-up. The Council approved the Tuberculosis Committee's recommendation that there be an amendment to the Department of Health's regulations which would exempt persons under 20 from having chest x-rays in order to work as food handlers. The Nursing Home Survey was referred back to the Chronic Illness and Aging Committee for more information. Eli Lilly's offer to make a contribution to the Association rather than put up a display at the annual meeting was declined. Mr. Bob Johnson was appointed the Association's official photographer with the idea that at some future date a bound roster with photographs will be considered. A chart of organization for the Association offices was approved and the employment of Mr. William E. Dodge as Administrative Assistant on a one-year contract was confirmed.

At the January 29 meeting a letter from a member of the Dental Association suggesting action be taken to protest the gross income tax on professional services was reviewed and referred to the Public Relations and Legislative Committees. A second insurance firm, Alexander & Baldwin, was authorized to solicit members for group insurance. However, A&B did not carry out their proposed project. It was voted to include all HMA employees in the Retirement Plan as set up by the Honolulu County Medical Society. This plan has not yet been put into operation. The Council voted to pay for employees' and guests' meals out of the entertainment account when their presence is required at meetings. The Council made formal request that the Association's senior representative on the Board of Management of the Mabel Smyth Building transmit information resulting from Board meetings to the Council. A policy was set to pay the amount of the HMSA single subscriber fee to employees who are already covered under HMSA through their spouse's employer. Authorization was given to the Honolulu County Woman's Auxiliary to combine their AMA-ERF party with the annual meeting banquet. This arrangement was subsequently abandoned. The Medicare Contract was extended to the customary expiration date in August. The Council voted to approve Medical Education Committee's resolution. The Committee would strongly favor an extension of the present Biological Sciences at the University of Hawaii to include a Biomedical Science Program provided that it is properly staffed and with sufficient funds to carry out a program of excellence—with three additions: (1) That this is a two-year program; (2) that the expenses for other areas of education should also be upgraded; and (3) that we approve the report on the principle that this program will be one of excellence. The Nursing Home Survey form developed by the Department of Health was approved. The following members were appointed to the HAMPAC Board: James Matayoshi, Chisato Hayashi, R. J. McArthur, P. H. Liljestrand, B. A. Richardson, George Goto, John Chalmers, John C. Carson, Maurice de Harne, P. M. Cockett, Mrs. Donald Jones. A lengthy report was made by Dr. Daniel D. Palmer on pharmacy. The President was requested to appoint a committee to work on pharmacy with the Department of Health, and report back to the Council. The Department's report was approved in principle.

At the March 4 meeting it was voted not to endorse the Legislative Committee's support of the Department of Health's bill setting up temporary licensure. Approval was given the Mental Health Committee to make application for funds from NIMH to be used for courses to be given specialty groups. The administrative fee will accrue to the Association. The result of the Council poll that was made by mail was announced and permission was given the JOURNAL to accept cigarette advertising. Dr. Allison proposed that there be an interim meeting of the House of Delegates in January and the Council pointed out that it was his prerogative to call this meeting. It was voted to form a Publications Committee to oversee the publication and finances of the HAWAII MEDICAL JOURNAL and to rule on editorial, publishing, and advertising policies. There was considerable discussion on whether the President and the Editor should be permitted to express their personal opinions in the JOURNAL. A motion that would permit the President to use his page of the JOURNAL as he wishes was lost. No further action was taken on editorial policy. It was voted to get an up-to-date poll of the membership on the Medical Practice Act.

At the April 8 meeting a lengthy report was made by Dr. George Mills on the fee survey, the medical care payments program of the Department of Social Services, and the involvement of hospitals in the Legislature's mandate to put DSS medical care out to bid. Dr. John Chalmers attended the meeting to discuss his Legislative Committee report. Although no action was taken, there was considerable discussion about leadership in the various health agencies and the Oahu Health Council in particular. The staff was ordered to secure information on the make-up of the Board of Directors and report back at the next meeting. It was determined that there are no effective evaluating agencies of voluntary health agencies and so the previous ruling that donations to these groups will continue on an individual basis will remain unchanged. The interim meeting on the neighbor islands was approved inasmuch as there was considerable interest shown. There were 275 responses to the postcard questionnaire, 150 of whom were interested in such a meeting. It was decided not to poll the membership on the Medical Practice Act at the present time but to wait until a committee is appointed to review the present Act and make recommendations.

The Council recommends that the 1965 Annual Meeting be held in Honolulu April 29 through May 2.

RANDAL A. NISHIJIMA, M.D.

Secretary's Report

Your Reference Committee reviewed with interest the report of the Secretary. The Secretary's report summarized many important actions of the Council throughout the year. These actions have been published as Council minutes verbatim in the JOURNAL. However, to keep the membership informed of current activities, your Reference Committee recommends that important actions of the Council be communicated to the membership in the monthly Newsletter.

Your Reference Committee accepts the recommendation of the Council that the 1965 Annual Meeting be held in Honolulu from April 29 to May 2.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TREASURER'S REPORT

The income for the 1963-1964 period, in all likelihood will be less than set forth in the 1963-1965 budget inasmuch as it now appears that the meeting planned to follow the AMA SF meeting will not be as well attended as had been anticipated. To date, less than 20 reservations have been made with the travel agent. The Budget was based on an attendance of 200. If this does pick up and the meeting is well attended, an arrangement has been worked out so that the AMA Hawaii delegation's return tickets from San Francisco will not be an Association expense item.

There have been unexpected repair expenses due to breakdown of equipment. There has also been extra maintenance expense in painting, etc., involved in the move. Since it was not known when the move of the executive offices would take place, no allowance for this was made in the 1963-1964 budget. No outside help was employed to handle the moving and all work was done by the Staff and friends. The move entailed considerably more than the physical change since the material that had been collecting in the attic for many years had to be sorted.

It was not felt advisable to order the furniture before renovation of the stock rooms was actually started and so there has been a delay in the arrival of the furniture, most of which should arrive before the annual meeting. The total cost cannot be given at this time since in order to effect a saving the furniture was ordered on the basis of list less 40% FOB mainland plant. The area now occupied by the executive offices was never meant to be used for anything but storage space. Many problems have come up because of this. One of the most annoying has been the acoustics. The ceiling is higher than the ceilings in the rooms on the rest of the second floor and no acoustical material was used. To compensate for this, the Council approved the purchase of drapes and floor covering. If the condition is not corrected, I feel the building management, which was aware of this deficiency before the remodeling began, should be responsible for correcting the acoustics.

An added expense in draping the windows has been made necessary by the lack of individual thermostats in the airconditioning system. The drapes are being lined with material that is supposed to reflect 40% of the heat. As it is now, the afternoon sun coming through the large window area keeps the HMA offices quite warm, while on the other side of the building where HCMS is now located, the offices are often too cold for comfort.

Insofar as the 1964-1965 budget is concerned, there has only been one committee request for funds. The Mental Health Committee would like $1,000 to cover the travel of two people to the national conference in Chicago. They had a budget of $500 this year but the AMA paid for the transportation of three people and so this was not used. In addition, the June Conference resulted in a net gain for that account.

The fixed expenses for 1964-1965 are based on a membership of 545 Honolulu, 45 Hawaii, 30 Maui, and 10 Kauai dues-paying members. The JOURNAL although listed as a deficit item of $1,660 in the income anticipated actually does not operate as an expense to the Association since $7,000 from the JOURNAL income is credited back to operating expense. Annual meeting income is based on the recommendation that doctors who are not members pay a registration fee of $25 vs. $15 for member doctors. It is also based on four additional exhibitors. The new auditorium complex, if used, may alter this figure considerably but at the present time rental fees for using this complex are not available.

On the expense side of the ledger it should be noted that the AMA meetings are more distant in 1965—Miami and New York instead of Portland and San Francisco. The Council expense is based on four meetings in Honolulu. The possibility of holding a Council meeting on a neighbor island has not been taken into consideration as it is probable that if this is done, the additional expense may be equalized by a registration fee; i.e. if 10 mainland doctors attend at $25, that would offset the expense to a considerable extent. The rental figure utilizes the new $264 a month figure vs. the former $154. The Council has the new figure under consideration.

The salary figure reflects annual increments and the retirement figure is based on 10% of the total annual salary of full-time employees. Telephone expense will be higher because of two additional telephones. Contemplated changes in this service have not been taken into consideration. Taxes reflect the increase in the Social Security tax plus slightly higher salaries. The Woman's Auxiliary figure is based on the standard $5.00 a member subsidy set by the House of Delegates. The furniture and fixture account takes into consideration a new adding machine and a dictating machine, plus incidental items which will be needed. The travel has been increased in order to maintain better communications with the neighbor islands. The Council has approved and urged the President-Elect to accompany the President on his regular inter-island circuit.

The balance between the operating expenses $54,010.00 less $7,000 reimbursement from the JOURNAL amounts to $47,010.00. This amount deducted from the anticipated total income $70,930, leaves a balance of $23,920.00 to be distributed among the committees or $8,420.00 less than 1963-1964. It will be noted that the operating expenses are estimated to be roughly $4,000 more than the present budget. Generally speaking, this is attributable to the increased rent and to the retirement fund.

Committee expense should be lower in some of the public relations field because of the nonrecurring allotment for the proposed Gill-Annis debate and the availability of outside funds for the Message of the Month flyers. In addition, after submitting the job out for bid, the cost of these flyers has been lower than anticipated. The savings this year, however, was absorbed by the printing of the Kerr-Mills flyers which were used for one of the messages. Another saving will be reflected in the Medical Care Plans & Fees Committee because of the nonrecurring items in that budget; i.e. the 1963-1964 budget was $7,420. This committee's expenses for 1964-1965 will mainly involve the printing of the RVS.

The two committees which will probably make requests for the major portion of the Committee budget will be the Legislative and Public Relations Committee. Their 1963-1964 budgets were $5,980.00 and $15,930.00, respectively. The Legislative Committee will require a much higher budget in 1963-1964 because of the longer session.

It is the Council's recommendation that at the annual meeting, the committee chairmen of those committees requiring budgets present their anticipated expenses. It will be the responsibility of the reference committees to include in their recommendations, budgets for the committees coming under their review.

The Council has approved the recommendation that the complete budget not be published in the JOURNAL until after the end of the fiscal year and the auditor's report has been completed and presented to the Council.

All reference committees which are charged with making recommendations on committee budgets are asked to confer with Dr. Richard Moore's reference committee prior to their executive completive sessions.

The following operating expenses were approved by the Council:

	1963-64 Budget	1964-65 Proposed Budget
Income:		
Membership Dues	$60,000.00	$63,000.00
Journal	(3,467.00)	(1,660.00)
Annual Meeting	5,380.00	6,640.00
Interest Income	1,800.00	2,200.00
Miscellaneous Income	700.00	750.00
Assessments	4,000.00	—
Post AMA Meeting	5,000.00	—
	$73,413.00	$70,930.00
Expenses:		
AMA Conventions	$ 2,910.00	$ 3,220.00
Audit and Accounting	1,580.00	1,580.00
Auto Expense	600.00	600.00
Council—		
Travel	280.00	380.00
Meals	230.00	280.00
Per Diem	180.00	240.00
Donations	20.00	20.00
Entertainment	400.00	400.00
Insurance	400.00	760.00
Library Contribution	100.00	100.00
Miscellaneous	470.00	400.00
Postage—		
Stamps	900.00	1,000.00
Bulk Mailing	300.00	300.00
Permit	20.00	30.00
President's Contingency Fund	500.00	500.00
Rent	1,850.00	3,170.00
Repairs and Maintenance	150.00	200.00
Retirement	570.00	2,550.00
Salaries	27,190.00	28,600.00
Stationery, Printing and Supplies	1,500.00	1,500.00
Subscriptions and Dues	840.00	810.00
Taxes	650.00	1,120.00
Telephone and Cable	1,500.00	2,000.00
Travel	150.00	500.00
Woman's Auxiliary	3,000.00	3,150.00
Furniture and Fixtures	3,500.00	600.00
	$49,790.00	$54,010.00
Committee Expense	32,340.00	23,920.00
	$82,130.00	$77,930.00
Less Journal Reimbursement	7,020.00	7,000.00
Total Expenses	$75,110.00	$70,930.00
Total Income over Expenses	(1,697.00)	

Committee expense figures are being mimeographed and will appear as an addendum to the delegates' handbook.

Herbert Y. H. Chinn, M.D.

Treasurer's Report

Your Reference Committee gave lengthy consideration to the report of the Treasurer. It views with alarm the fact that the operating expenses are estimated to be roughly $4,000 more than the present budget.

Your Reference Committee concurs with the recommendation of the Reference Committee on Public Health that the request for $1,000 for the Mental Health Committee and the request for $340 for the Diabetes Committee be eliminated. The Reference Committee questions the necessity of allocating $300 in travel expenses to the Maternal & Perinatal Mortality Study Committee and recommends that it not be approved. At the time of the preparation of this report, your Reference Committee had not received recommendations from the other reference committees relative to budgetary requests. In an effort to have a balanced budget, your Reference Committee strongly recommends that the sum of $2,480 be deleted from the Public Relations Committee budget.

Your Reference Committee gave careful consideration to a request for $500 for HAMPAC but denies this request because of our budget deficit.

ACTION:

It was moved to amend the motion by deleting the portion which recommended that the sum of $2,480 be deleted from the Public Relations Committee's budget. The motion was not carried.

It was felt that it is extremely important for the Public Relations Committee to have this money in their budget even if they do not use all of it.

It was moved to approve the report with the amendment that if the Public Relations Committee needs additional financial support that they be encouraged to return to the Council in obtaining these funds. The motion was passed.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

The Chairman recommended adoption of this report as a whole as amended. It was adopted.

Your Reference Committee wishes to thank Mrs. Heather Akana for her valuable assistance in the preparation of this report.

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 18 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussions of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AUTOMOTIVE SAFETY COMMITTEE

The Automotive Safety Committee of the Hawaii Medical Association was formed in the latter part of this fiscal year and managed to meet on March 13, 1964. This was a round-table discussion dealing with organizational matters for this new committee in which many ideas were promoted. It was unanimously agreed that a committee such as this could serve a real purpose within the community and after basic organizational efforts are fulfilled, we will pursue a rather vigorous course pertaining to the health aspects of automotive safety.

James G. Marnie, M.D.

Automotive Safety Committee

Your Reference Committee first considered the report of the Automotive Safety Committee. No one appeared to discuss this report.

Your Reference Committee feels that this Committee has much work of value that it can do and is particularly interested in seeing a follow-up on the Heart Committee's recommendation that persons who have had heart ailments in an acute phase should not necessarily be put on a five-year waiting period before being allowed to drive a vehicle for commercial purposes. Each case should be determined individually.

It is recommended that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEART COMMITTEE

This Committee had several interesting meetings since June, 1963. In the first meeting a motion picture entitled *Heart Attack* was previewed for the Health Department. It was considered that the previous film entitled *Pulse of Life* was superior and the former film should not be purchased. In the next meeting the following topics were discussed: (1) Cardiac detection program with the mobile TB survey. (2) Closed chest cardiac resuscitation program.

In the February meeting the Committee voted to accede to the Disaster Committee's request that the Heart Committee amend its previous ruling that a physician be present when the film *Pulse of Life* is shown to medical self-help classes; however, the Heart Committee would like to add that when the film is shown to other groups that a physician or someone well-trained in cardiac resuscitation be present. This Committee also voted to recommend that the Automotive Safety Committee review the five-year waiting period established by the Public Utilities Commission for cardiac cases with the idea in mind of establishing a more realistic criterion.

It was also voted to approve the printing of the revised follow-up forms to be used in the cardiac mobile suspect cases picked up by the x-ray program.

In the final meeting held in March, 1964, Dr. Abraham Kagan of the U. S. Public Health Service outlined the proposed five-year study of cardiovascular diseases among the Japanese in Hawaii which is to start in 1965. The Heart Committee voted to approve the proposed study and submit their recommendations to the House of Delegates for their approval. It was also voted that the National Heart Institute be given cooperation of the Hawaii Medical Association.

I recommend that the next committee study the proposal that a rheumatic fever registry be established in Hawaii.

COOLIDGE S. WAKAI, M.D.

Heart Committee

Your Reference Committee considered the report of the Heart Committee. A full and complete discussion of the subject was had. Dr. Quisenberry joined in the discussion of this report, representing the Department of Health and the Reference Committee feels that the study to be made by the National Heart Institute is worth while and deserves the full approval of the HMA. It is recommended that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DIABETES COMMITTEE

The Committee felt that this year was one of accomplishment. We were helped immeasurably by the Department of Health, which in addition to lending us the Clinitron, furnished personnel to help with the screening procedure. The Woman's Auxiliary was also most helpful to our program.

Although the returns are incomplete, the following table lists the results of our November Honolulu survey:

Total screened	1,658
Total screened positive	211
1. Total previously known diabetics with positive tests	35
2. Total previously unknown diabetics with positive tests	176
Total previously unknown diabetics with positive tests referred to physicians	176
Total number diagnosed as known diabetics	24

The Kauai results have not been received.

In addition to the November screening, the Department of Health working through the Committee with the approval of the various county societies is continuing to operate the Clinitron in rural Oahu as well as on neighbor islands. It is felt by the Chairman that this is a worth while project and should be continued and even augmented if practical, with the same budget.

In closing, I gratefully thank all members of the Diabetes Committee as well as those who worked with us for the success of the past year, especially Miss Harriet Kuwamoto, whose services have been invaluable.

L. G. STUHLER, M.D.

Diabetes Committee

Your Reference Committee next considered the report of the Diabetes Committee. A full and complete discussion of the subject was had.

Dr. Quisenberry joined in the discussion, representing the Department of Health.

Your Reference Committee feels that the Diabetes Committee should be left intact at the State level but that the budget be deleted and that any costs incurred should be taken over by each County.

It is recommended that this report be accepted with the deletion of the budgetary request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

EXAMINING BOARD FOR HANSEN'S DISEASE

The Association's representative was called upon to meet with the Board to examine ten patients—twice as many as the previous year.

MICHAEL M. OKIHIRO, M.D.

Examining Board for Hansen's Disease

Your Reference Committee next considered the report of the Examining Board for Hansen's disease. Dr. Hirschy represented the Department of Health and was appreciative of the Board's response to their requests for examination and pointed out that they had been most cooperative.

It is recommended that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNICABLE DISEASE & IMMUNIZATION COMMITTEE

The Committee has met frequently during the year to discuss and make recommendations to Dr. West in this area. During the first meetings, the Committee set forth certain objectives for the year, to wit: (1) To review the immunizations currently available and to recommend a schedule which might be mutually agreed upon by the Association and the Department of Health. (2) After having agreed upon this schedule, to recommend coordination of all Medical Association and Health Department facilities in an educational program for the State. A representative of the HMA Public Relations Committee met with the Committee and assured it that the PR Committe would prepare and launch such a coordinated program as soon as the schedule was ready. With high hopes, we began by considering the present status of oral polio immunization in Hawaii. With much concern it was noted that Sabin Types I and II were not being given in quantities sufficient to maintain the immunity level acquired during the Swallow program and that Type III, even though the USPHS and Academy of Pediatrics had approved it, was being given only by a few doctors in private practice.

As of December 14, 1962, 483,883 doses of Swallow I had been given (72.2%) and 479,862 doses of II (76.4%). The Department of Health has advised that the following number of doses of polio vaccine have been sold:

	TOTAL 1963	LAST QUARTER OF 1963
Salk	59,966	13,641
Type I	5,395	1,910
Type II	4,415	1,535
Type III	37,264	4,854
Trivalent	1,085	1,085

It should be noted that of the 59,966 doses of Salk, 18,198 were purchased by the Department of Health. Also that trivalent Sabin did not become generally available until the third quarter of 1963.

It was felt that by a combined endorsement of the State Health Department and this Committee that we could generate enough interest in the population of the State to acquire good levels in all three types.

The next three meetings were largely devoted to working with the Health Department towards this end. There appears to be an overly cautious attitude on the part of the Health Department which has made increasing demands before taking a stand on this issue. First, it was necessary to furnish proof that the oral vaccine was superior to the injectable, and more effective. After this became obvious, a request was made for endorsement by the Academy of General Practice and the Pediatric Society. This was accomplished as well as the endorsement of the Hawaii Society of Internal Medicine at a joint meeting with the Pediatric Society. The last request of the Committee has been that a letter from each County Society should also be sent to the Health Department. We are complying with this additional request even though it seems redundant as this Committee represents all of the counties and has members from each county on it. Dr. West met with Maui County and obtained its approval. Letters have been sent to the counties of Hawaii, Kauai, and Honolulu requesting endorsement.

To the new committee we are sorry that we have not completed our objectives. If we have allowed ourselves to be delayed and if an epidemic of Type III polio strikes the islands, we have been in error. However, the value of a coordinated program seemed to us to outweigh the risk. If this is not accomplished in the near future, I shall be pleased to brief the new committee more fully and assist in every way possible to get the program off the ground.

The Committee has also worked with the Health Department on the other immunizations and reviewed current recommendations.

JOHN H. PEYTON, M.D.

Communicable Disease & Immunization Committee

Your Reference Committee next considered the report of Communicable Disease and Immunization Committee. A full and complete discussion of the subject was had. Dr. Ira Hirschy and Dr. Walter Quisenberry joined in the discussion. Dr. Hirschy pointed out that they were still using a considerable amount of Salk Vaccine because they were familiar with its background and what it could accomplish. Dr. Quisenberry discussed the use of a live attenuated vaccine as compared to an inactive or "dead" vaccine. The remainder of the report brought forth no comment except to urge all physicians to cooperate in polio immunization.

It is recommended that this portion of the report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER COMMITTEE

No meetings of this committee were held and no problems were referred to it. The annual report of the Cancer Commission was not submitted.

HAROLD M. JOHNSON, M.D.

CANCER COMMISSION

During 1963-64 the Cancer Commission met monthly to take up matters concerning the Hawaii Tumor Registry. Hospitals and physicians in the State have continued to cooperate in the program, and data accumulating in the Central Registry are becoming increasingly valuable in the study of neoplastic disease in Hawaii. Of particular importance to the success of the Registry system from this point on will be the cooperation of individual physicians in supplying to hospitals the annual follow-up information concerning patients, which is now being requested by the hospital registries.

A compilation of data for the three years 1960 through 1962 will be available at the annual meeting of the Hawaii Medical Association at the end of April, 1964. A further, more detailed report for the four-year period 1960 through 1963 is in preparation, and probably will be issued in July or August of this year.

GROVER H. BATTEN, M.D.

Cancer Committee

Your Reference Committee next considered the report of the Cancer Committee. No one appeared to discuss this report.

A letter from the Cancer Commission to the Cancer Committee was read. Your Reference Committee feels that all physicians in the State should cooperate in every way possible to make the Tumor Registry successful per the request of Dr. Batten, Chairman of the Cancer Commission. This constitutes the only report from the Cancer Committee and it is recommended that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH COMMITTEE

This committee, consisting of 13 members, met six times during the year. The HMA Conference on Mental Health, June 25 and 26, 1963, was planned and carried out by a subcommittee with the cooperation of the Mental Health Association of Hawaii, the Hawaii Academy of General Practice, the Hawaii Psychiatric Society, and the Mental Health Division of the State Health Department. The conference attracted 188 participants in spite of the newspaper strike. Of these 65 were physicians, not including the five invited guest speakers. Although the HMA Council had voted a $200 budget for this event, the final accounting indicated a profit of over $100, which will revert to the general funds.

In the fall of 1963 the House of Delegates voted a $500 budget to the Committee to send a delegate to the AMA Annual Meeting of State Mental Health Representatives in Chicago. Because for the second successive year the AMA carried out the unprecedented act of paying the expenses of not one, but three delegates, this amount is also being returned to the HMA treasury.

Members of our committee participated on behalf of the Association in many other community efforts in mental health. The chairman continued to serve on the steering committee of the Second Governor's Conference on Rehabilitation of the Mentally Ill Adult, September 1963. Final publishing of the recommendations from the Governor's Conference has been delayed by an avalanche of work created by the massive State Planning for Mental Health projects for which there are two years' funds provided by Congress. The Medical Association contributes the Medical Director and two members of the State Planning Committee (17% of the latter), while one of five members of each County Steering Committee represents each County Medical Society. Additional physicians serve in *ex-officio* capacity and on the numerous task forces. Regrettably, while this is going on the Advisory Committee to the Director of Health on Mental Health (which had originally been suggested as an advisory committee to the Governor) has not been convened.

Pursuant to last year's plans and at the direction of the 1963 House of Delegates, the Committee has discussed and investigated, with the HMSA and a representative of the private insurance industry in Hawaii, the possibility of increasing insurance coverage for mental

illness. One full committee meeting and several exchanges of information have led to better relations. The insurance industry throughout the United States, while gradually increasing mental illness coverage for groups, is demanding standardization of psychiatric practice before extending similar benefits to individual policy holders. Continued correspondence and cooperation are required.

The Committee has also considered several matters of legislative significance. We were unable to come to agreement concerning licensure or certification of psychologists, but did agree to refer to the Legislative Committee a proposal for amendment of the Medical Practice Act so as to clearly include any effort to modify or alter by any means any person's mental behavior or emotional state or habitual functioning. Four bills relating to practices relative to licensing of private institutions, providing expeditious hospitalization of dangerous mentally ill patients and voluntary admission of patients to private institutions were recommended to the Legislative Committee and their passage diligently pursued. However, they failed to clear the third reading in the House because there was insufficient time at the end of the session. We also backed a bill for reporting psychiatric patients to a central registry, which was passed by both Houses. And finally we discussed a proposed salary scale for government-employed psychiatrists which would raise salaries very significantly in order to make them competitive with going Mainland opportunities.

RECOMMENDATIONS:

1. That in 1964-65 the Committee follow-up programs related to insurance coverage of mental illness, the state planning for mental health, the Medical Practice Act's definition of the practice of medicine, salaries of government physicians, and the Conference on Mental Health. In relation to the latter, it should submit an application to the National Institutes of Mental Health for a grant for a program of courses in psychiatry specific to various specialties in medicine, as approved by HMA Council.

2. That HMA approve a budget of $1,000 to the Mental Health Committee for: (a) costs of a followup project to last year's Conference on Mental Health, and (b) expenses for one delegate to the Second AMA Congress on Mental Health, November, 1964, and one delegate to the Annual Conference of State Mental Health Representatives, February 1965.

GEORGE F. SCHNACK, M.D.

Mental Health Committee

Dr. Wallis and Dr. Schnack were present to discuss this report.

Your Reference Committee feels that the work of the Mental Health Committee is important and was well done during the past year. It is recommended that their report be accepted but that the second recommendation, namely, the approval of the budget of $1,000 be deleted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL EDUCATION COMMITTEE

This newly formed committee was appointed in October, 1963, to serve as liaison to and to act in an advisory capacity to the University of Hawaii in matters relating to medical education. The immediate concern was the proposed Biomedical Science Program which was introduced when this committee was formed. Six formal meetings were held during the three-month period to understand and to evaluate this proposal. Meetings were held with Drs. Robert Tschirgi and Richard Lockwood, the project director and associate respectively. The accumulated information was released to the membership in a condensed form, and they were invited to an open hearing to convey their reactions to the committee.

After due consideration, the committee adopted the resolution: This committee would strongly favor an extension of the present biological sciences at the University of Hawaii to include a biomedical science program, provided that it is properly staffed and with sufficient funds to carry out a program of excellence.

On January 29, 1964, this recommendation was presented to and adopted by the Hawaii Medical Association Council.

The committee will continue to maintain close liaison with the University of Hawaii in regards to this proposal or any other matters related to medical education.

RICHARD T. MAMIYA, M.D.

Medical Education Committee

Dr. Richard Lee from the University of Hawaii appeared to discuss the report. He assured your Reference Committee that financing for the Biomedical Science Program was being carefully investigated and is still to be worked out. If financing is worked out, it will be at least 1968 or 1969 before this department will be ready to accept students. He requested that a liaison committee between the HMA and the University be kept intact. It is recommended that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MATERNAL AND PERINATAL MORTALITY STUDY COMMITTEE

The objectives of the Committee are: (1) To study all maternal deaths and a selected number of infant deaths by full scientific analysis and unrestricted discussion of all factors involved with rigid adherence to ethical and legal principles so that anonymity of all parties involved may be maintained; (2) To determine the existence and nature of avoidable factors so that these may be reduced or eliminated; (3) To make an objective and impersonal report and disseminate knowledge gained so that better maternal and infant health care may be assured through improvement in teaching and practice; and (4) To serve as an advisory committee to the Department of Health on programs relating to maternal and child health.

Major activities of the Committee for 1963 were as follows:

1. The Committee studied in detail four maternal deaths. One of these deaths was considered nonobstetrical and three were considered directly obstetrical. The one nonobstetrical death was due to unrecognized subacute bacterial endocarditis with septic emboli and acute rheumatic heart disease. Two directly obstetrical deaths followed rupture of the uterus; the third directly obstetrical death was due to complications following an elective cesarean section. The calculated maternal mortality rate for 1963 was 1.7 per 10,000 livebirths, which is significantly below the death rate for the United States as a whole. In spite of this reduced mortality rate the Committee would like to emphasize that all deaths for 1963 were definitely preventable.

2. The subcommittee on Perinatal Mortality, chaired by Dr. Donald Char, met at monthly intervals in addition to the regular meetings of the Committee as a whole. This Subcommittee selected perinatal deaths which would be of interest to all Committee members on the basis of autopsy diagnoses on the death certificates. Nineteen perinatal deaths were studied by the Subcommittee and of these, nine cases were considered noncontroversial and nonpreventable and the studies were terminated in this Subcommittee. One fetal death was presented and discussed at one of the hospitals in the neighbor islands at the request of the Chief of Staff of that hospital. Of the

nine cases that were presented to the Committee as a whole, five cases were considered directly obstetrical deaths of which two were considered possibly preventable and three practically preventable; two cases were considered to be pediatric deaths and of these one was possibly preventable and one practically preventable; one case was considered to be a combined pediatric-obstetric death but was unclassifiable as to preventability; one case was considered practically preventable but was unclassifiable as to assignment to pediatric or obstetric cause of death.

3. This Committee in cooperation with the Legislative Committee has had enacted by the Second State Legislature and signed into law by Governor Burns, Act 109. This law has greatly facilitated the investigations of this Committee and in-hospital staff committees (whose main objective is to reduce mortality and morbidity) because it provides immunity from unjustified legal action. Because this law protects the records and members of the above-mentioned committees and those who furnish information to the committees, participation by members of the Association and the various hospitals' paramedical personnel has increased. We are gratified in seeing genuine interest and acceptance of the activities of these committees by all concerned. In order to comply with the provisions of this law in regard to confidentiality of clinical records we have revised and adopted new classification forms.

4. We have requested the State Department of Health to pass a regulation so that the death of a woman who is pregnant or within 90 days postpartum becomes reportable. We have taken this action because women who die of causes other than obstetrical but within the definition of a maternal death may not be identified as study cases.

5. Letters of inquiry were sent to all the county governments regarding the Medical Examiner's system in this State as requested by the Chairman of the Senate Public Health Committee during the second general session of the State Legislature. The information requested was expenses and present mode of operation and cost projection in each county. We have received the requested information from the City and County of Honolulu and County of Maui. We hope to receive the necessary information from the Counties of Hawaii and Kauai in the near future so that a bill similar to Senate Bill No. 1179 of the Second State Legislature may be assured passage during the next general session in 1965.

6. Following requests from members of the Association on the Island of Kauai several members of this Committee attended meetings at the Wilcox Memorial Hospital on June 11, 1963, and again on January 14, 1964, to discuss maternal and perinatal death cases which occurred at this hospital. We wish to report that our visits were well accepted except for differences of opinion regarding the presence of paramedical personnel (who were involved in the care of these patients) in these particular meetings. We wish to reiterate that the primary purpose of this Committee is educational and not punitive. For this reason we feel that paramedical personnel should be allowed to attend these meetings, upon invitation, for this express purpose. The fear that legal action may result has been minimized by the passage of Act 109 described above.

7. This Committee has been trying to persuade the major general hospitals in the State to conduct perinatal mortality and morbidity studies within their respective hospitals in cooperation with this Committee. This was suggested to the House of Delegates during the meeting of September 7 and 8, 1963. The medical staff at Hilo Hospital has expressed an interest in this area. In order to explore this possibility further Dr. Edward C. Hughes, Professor of Obstetrics and Gynecology, State University of New York, Upstate Medical Center in Syracuse, New York, consented and did go to Hilo in February to explain the mechanics of this Perinatal Mortality Study Committee at the Hilo Memorial Hospital.

As we have stated in our letter of June 24, 1963, we are requesting the yearly appropriation of $300 to this Committee for travel and lodging expenses for members of this Committee and visiting professors to make possible trips to the Counties of Kauai, Maui, and Hawaii, for conferences to improve the quality of medical care in obstetrics and pediatrics. We have found that these visits are worthwhile and well attended and hope to continue making future visits if at all possible.

During the past budget session of the State Legislature the Joint Conference Committee of the House Finance and Senate Ways and Means Committee recommended in their report that the Maternal and Child Health Section of the State Department of Health should completely phase out its maternal health program. The report does not make entirely clear what is meant by phasing out of the maternal health program because as the situation now stands prenatal care for indigent patients is conducted in only three areas of the State where private medical facilities are not available. If private care becomes available, the State Department of Health will then phase out their activities in these areas. If the intent of the Joint Committee Report means phasing out of these programs when the need becomes minimal we are in agreement with it. However, if the intent of the report is to eliminate the maternal health aspect from the position of the Chief of Maternal and Child Health Section and her clerk-stenographer, we feel a grave error is being made. The supervisory and surveillance activities of the area of maternal health should be allowed to continue for the sake of insuring optimal maternal health in this State. For these reasons we recommend that the Governor, the President of the Senate, and the Speaker of the House of Representatives be informed of the concern of the Association in this area and that the Joint Conference Report in this area should be further clarified.

GEORGE GOTO, M.D.

Maternal & Perinatal Mortality Study Committee

Its chairman, Dr. George Goto, and Dr. Katherine Edgar, from the Department of Health, were present to discuss this report. A full and complete discussion of the subject was had with these persons. The representatives on the Reference Committee from the neighbor islands were convinced that the visits to the other islands of members of this committee are important and worth while. Dr. Edgar pointed out that her department pays for transportation from the other islands to Honolulu for the Annual Meeting.

Your Reference Committee recommends approval of the requested budget. Your Reference Committee feels that this report should be accepted in total.

ACTION:

It was moved to allow Dr. Goto to speak on behalf of this report. The motion was carried.

Dr. Goto said he felt when people are asked to travel to neighbor islands to discuss maternal and perinatal deaths that the HMA should pay their travel expenses. It was noted that the Department of Health pays for two physicians. It was also noted that this committee only spent $63.15 last year. Dr. Goto was asked if the Department of Health could pick up the tabs as they did last year. He said that since the Department of Health's budget had been cut, he did not know if they could still pay these expenses. The Department of Health has not been approched regarding financial help for this year. Dr. Wipperman asked if specialists on the neighbor islands could help in some way so that there would not be the expense of sending two people from Honolulu. It was noted that if physicians were used from the neighbor islands, a true picture would not be obtained.

It was moved to delete the last sentence of the Reference Committee's report.

The motion failed to carry.

The Chairman moved adoption of this portion of the report. It was adopted.

RADIATION COMMITTEE

No problems occurred or were presented and no meetings held.

GEORGE W. HENRY, M.D.

Radiation Committee

Since the Committee had no problems and no meeting, the Committee had no comments.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

THE SCHOOL HEALTH COMMITTEE

HEALTH COORDINATOR PROGRAM: The Committee had actively considered the problem of the Health Coordinator Program of the Department of Education a year ago and was very concerned over the proposed dropping of this program by the Department of Education. A special meeting was held in January, 1964, with Dr. Richard Ando and Mr. Edwin Honda, representing the School Advisory Board and Board of Education. The proposal by the Department of Education to drop this program was based on the lack of budgetary funds. After much discussion the Committee voted unanimously to push for a more expanded budget to maintain the Health Coordinator Program in the public schools. Attempts were made during the Legislature's budget session to inform the legislature about this program, but unfortunately the program was not included in the final budget.

SCHOOL EXAMINATIONS FOR THE 7TH GRADERS: The problem of the annual school physical examinations for 7th graders was discussed at length at the earlier meetings. The School Health Committee has attempted in the past year, with the help of the Department of Health and the Department of Education, to cover as many 7th graders as possible with a complete physical examination at this grade level. The program has been successful on Oahu the past two years, but unfortunately now with the elimination of Health Coordinator Program this will no longer be possible. In the past two years the health coordinators played a very vital role in coordinating the attempts to have complete physical examinations on all the students. It is hoped that with return of the Health Coordinator Program that this school examinations for 7th graders could be returned also.

DISCUSSION CONCERNING PHYSICAL EXAMINATIONS FOR COMPETITIVE SPORTS IN PUBLIC SCHOOLS: A subcommittee was formed consisting of Dr. Edgar and Dr. Sia who met with Miss Kay Fossum from the Department of Education with a group of principals and coaches to discuss problems of physical examinations for competitive sports. The adoption of a new physical examination form for those participating in competitive athletics was brought forth and accepted by the School Health Committee. This was subsequently passed on to the various schools to be used by the coaches and athletic directors. It was the decision of the School Health Committee that physical examinations for competitive sports should be performed after June 1 or within three months before the sport concerned occurs and not more than one examination a year be required.

TUBERCULIN TESTING ON ENTRANCE TO PUBLIC SCHOOLS: It was a suggestion of Dr. William Moore that tuberculin testing be made compulsory on entrance to school. The School Health Committee discussed this program at length and felt that this should not be made compulsory at this time.

HEALTH HAZARDS IN CAFETERIA SERVICE: Because of the concern of many parents concerning the health hazards in the school cafeteria service, this question was raised to the School Health Committee. The School Health Committee did not feel that the cafeteria service was a health hazard problem. They did state that the following conditions were areas for excusing students from helping in school cafeteria: Infectious conditions, rash, ringworm, vomiting, diarrhea, convulsive disorders, etc. It was felt the students should be excused for one week following return from recent illness. A guide for screening students assigned to cafeteria service was sent out by the State of Hawaii, Department of Education, based on a list compiled by the Chairman as recommended by the School Health Committee of the Hawaii Medical Association.

DISCUSSION WITH MR. TATE ROBINSON OF THE DEPARTMENT OF EDUCATION REGARDING FIRST AID SUPPLIES: The School Health Committee made recommendations in regard to the purchase of new supplies for first aid as splints, cardboard leg or arm splints, and aluminum padded finger splints to be cut at any length desired in the schools. The Committee rejected the following items: burn sprays, spray-bandage, and self-sticking gauze as routine first aid supplies.

SEX EDUCATION IN THE PUBLIC SCHOOLS: A meeting was held with Mr. Tate Robinson to discuss the problem of sex education in schools. Mr. Robinson brought the instructional guide published by the Department of Public Instruction. The name of the guide is "Health and Safety Education of Public Schools of Hawaii." It brought forth the manner in which sex education is introduced to the school child. It was stated that the teaching of sex in various schools depended largely on the school's own initiative to start this type of program. The Committee felt that this area could be improved and appointed Dr. Robert Dimler to meet with the principals and teachers to organize a possible plan for in-service sex education for teachers.

PRENATAL CARE FOR TEEN AGE GIRLS IN SCHOOLS: A meeting was held with Mrs. Makekau to discuss the problem of the public health nurse's role in promoting better prenatal care of teen age girls in schools. It was the feeling of the Committee that the public health nurse is one of the resources for referral and that this should be done at an early stage of pregnancy. It is hoped that the principals and teachers would make the necessary early referral for resources if the teenager is unable to initiate this through private services.

SUMMARY: The Committee has felt that the important loss this past year has been with the Health Coordinator Program. This will undoubtedly affect many areas of school health in the ensuing years. It is of utmost importance that this program be returned to the public schools and the Medical Association take an active role in encouraging this program's return.

CALVIN C. J. SIA, M.D.

School Health Committee

A full and complete discussion was had. Dr. Calvin Sia and Dr. K. Edgar were present. It was pointed out that Dr. Dimler plans to meet with the principals and teachers to organize for in-service sex education and to see if the Medical Association can be of some help on this plan. In answer to the question of the role of the health coordinators, Dr. Sia pointed out that this person has to coordinate health screening, tuberculin testing, and many other problems which need proper coordination.

Your Reference Committee feels that the position of health coordinators in the school system should be restored.

It is recommended that this report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TUBERCULOSIS COMMITTEE

The Tuberculosis Committee met once on October 24, 1963, primarily to discuss the change in the Public Health Rules and Regulation of Chapter 23 providing that a

person under 20 years of age will not, except when specifically required by the Department of Health, be required to have an examination for tuberculosis in order to work as a food handler. Most of the discussion centered around statements made by Dr. Marks of the Tuberculosis Section of the Department of Health and he gave what seemed to be very good evidence that this rule should be so changed.

A short period of the meeting was taken up with the discussion of a proposed tuberculosis eradication program which will be handled by the Department of Health, financed primarily from Federal funds. This was approved in principle and the proposed changes to the Public Health Rules and Regulation were unanimously approved.

It was suggested that in the future such measures proposed by the Department of Health be brought to this Committee before public notice appears in the public press. A letter to this effect was sent to the Director of the Department of Health and this was answered at a later date. Since the Chairman was absent during the month of March and part of April, no meeting was held for lack of quorum on the subject of the tuberculosis eradication project which is now being implemented. This will undoubtedly be considered at a future date.

CHARLES F. BROWN, M.D.

Tuberculosis Committee

Dr. Quisenberry was present, representing the Department of Health. It was agreed that it is better for all committees to have a meeting with the Department of Health to discuss new problems before public announcements are made and this should help allay public apprehension.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

VENEREAL DISEASE COMMITTEE

No problems were presented and no meetings were held.

ROBERT K. MOOKINI, M.D.

Venereal Disease Committee

This Committee had no problems this past year. Since there is evidence that the venereal disease is increasing it may be that there will be problems in the coming year and your Reference Committee recommends that the new Committee ask the Department of Health to submit comparative statistics for its review.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 4

Re: Salaries for psychiatrists.

WHEREAS, Salaries offered psychiatrists by the State of Hawaii are uniformly within the lowest 15% of those offered by the several United States, District of Columbia, Puerto Rico, and the Veterans' Administration, and

WHEREAS, There are constantly unfilled positions for psychiatrists in the State Health Department, some of them having been vacant at some time for as long as three years, and

WHEREAS, Living costs in Hawaii are estimated to be 15 to 30% higher than in continental areas of the United States, and

WHEREAS, Travel to professional conferences and conventions, postgraduate training courses, etc., in order to maintain one's professional abilities and to keep abreast of advances in psychiatry are far higher in cost from Hawaii than from other areas of the United States, and

WHEREAS, The State of Hawaii has been unable because of these reasons to attract psychiatrists of national repute and highest caliber to work in State positions, and

WHEREAS, Because of these same reasons those psychiatrists who have been recruited traditionally have used government practice as a stepping-stone into private practice or have left Hawaii when prepared to take more responsible positions, and

WHEREAS, Such turnover also creates lowered morale in the public mental health service and institutions and consequently a lower level of patient care, and

WHEREAS, Such turnover also creates confusion in administration and disruption in philosophy, objectives, programs and staff development within the same mental health service and institutions; be it therefore

Resolved By the House of Delegates of the Hawaii Medical Association that this body recommend and work diligently toward establishment of salaries for psychiatrists in the employment of the State of Hawaii which are at least competitive with the upper half of comparable salaries offered by other of the United States; and the systematic continual review and revision of such salaries so that they remain in competitive position, in order that the people of Hawaii may have a reasonably effective system of mental health care and improved programs of preventive and community psychiatry; and be it further

Resolved, That the following suggested salary schedule for 1964-1965, which lies in the range between the 50th and 75th percentiles of salaries reported by the States, District of Columbia, Puerto Rico, and Veterans' Administration in 1963 and is estimated to lie between the 40th and 60th percentiles of salaries holding currently, be recommended:

Executive Officer, Mental Health Division	$25,000
Medical Director, State Hospital	
Deputy Executive Officer, Mental Health Division	$19,000-22,000
Clinical Director, State Hospital	
Clinical Chief, Diamond Head Mental Health Center	$17,000-20,000
Clinic Chief, Convalescent Center	
Supervising Psychiatrist, State Hospital	
Clinic Chiefs, Mental Health Services	$15,500-18,500
Clinic Chiefs, other Mental Health Centers	
Staff Psychiatrists, State Hospital	
Staff Psychiatrists, Mental Health Centers, etc	$13,000-17,000

Submitted by the MENTAL HEALTH COMMITTEE

Resolution No. 4

Your Reference Committee considered Resolution No. 4. Drs. Wallis, Schnack, and Allison were present. It was questioned whether the State Medical Association should take a stand relating to salaries for government employed physicians. An amendment to the resolution which would have eliminated the sixth paragraph was considered before final decision was reached. Your Reference Committee feels that the HMA has no right to be involved in a salary discussion. The resolution was rejected. The chairman advised that a minority report had been withdrawn.

ACTION:

The Chairman recommended that this resolution not be adopted. It was not adopted.

RESOLUTION NO. 3

Re: Relationship Between Cigarette Smoking and Chronic Respiratory Disease

WHEREAS, The Hawaii Medical Association is aware of its responsibility to the citizens of this State, and

WHEREAS, The smoking of cigarettes can lead to shortness of breath and developing a persistent cough, and

WHEREAS, Smoking is found to be significantly associated with the presence of chronic bronchitis and emphysema, and

WHEREAS, Cigarette smoking is highly associated with the presence of irreversible obstructive lung disease; now therefore be it

Resolved, That the Hawaii Medical Association wishes to acknowledge the causal relationship of cigarette smoking to chronic respiratory diseases; and be it further

Resolved, That this Association wishes to encourage the dissemination of information to the public regarding the relationship of cigarette smoking to chronic respiratory diseases; and be it further

Resolved, That the American Medical Association, through its Hawaii delegate, be asked to adopt a similar resolution.

Submitted by FREDERICK L. GILES, M.D.

Resolution No. 3

Your Reference Committee discussed Resolution No. 3. Dr. Giles was contacted by telephone to clarify his intent. He pointed out that cancer and coronary artery disease had been emphasized while chronic bronchitis and emphysema, which are very crippling, have been relatively ignored.

ACTION:

The Chairman moved adoption of this portion of the report. The differences between this resolution and the one passed last year were pointed out. It was adopted.

RESOLUTION NO. 1

Re: Federal Funds for Staffing Mental Health Center

WHEREAS, Community Mental Health Centers as envisaged by the Congress would be of great value to the mental health of the people of Hawaii; and

WHEREAS, Hawaii will be able to obtain its share of Federal funds for the construction of such centers; and

WHEREAS, Hawaii seems unable, or its Legislature unlikely to commit funds to the staffing of any such center, so that if built, they would become a drain of local funds to maintain and at the same time they would contribute nothing to the health and welfare of Hawaii's citizens, Now therefore be it

Resolved, by the House of Delegates of the Hawaii Medical Association, that it instructs its AMA delegates and all members to support an effort to have Congress authorize and appropriate funds for the staffing of such centers under a formula resembling that recommended by the AMA Council on Mental Health to the 1964 Annual Meeting of the AMA.

Submitted by GEORGE F. SCHNACK, M.D.

Resolution No. 1

Your Reference Committee considered Resolution No. 1. It was pointed out that no staffing can be done since Congress has deleted all funds and reference to them. The opinion was expressed that there is not much chance of Congress reconsidering this matter. The AMA's position of opposing Federal funds for staffing was reviewed.

ACTION:

The Chairman recommended that this resolution not be adopted. It was not adopted.

The Chairman moved the adoption of this report as a whole as altered and amended. It was adopted.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 17 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

ASSOCIATION OF PROFESSIONS

It is with great regret that I must report that insufficient time prevented my active development of the proposed Association of Professions during the past year. I still feel it is a worthwhile project and that this ad hoc committee should be continued. I would recommend that a chairman with more time to devote to the program be appointed to take over in 1964-65.

A. L. VASCONCELLOS, M.D.

Your Reference Committee first considered the report of the Association of Professions. A full and complete discussion of the subject was had.

Your Reference Committee feels that this problem could be best handled on an individual county level. It is recommended that this ad hoc committee be disbanded.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CAREERS COMMITTEE

If happiness comes from the satisfaction of a job well done, then the members of the Careers Committee are happy people.

The Second Annual Medical Careers Day for high school students held on Friday, February 21, 1964, repeated the success of the previous year. There were 125 students from Oahu and five students from Kauai who were taken on tours of the hospitals, shown exhibits, and taken to the doctors' offices. Seventy doctors participated. Each group of four students had one doctor host in the morning and a different doctor host in the afternoon. The students had breakfast at The Queen's Hospital and lunch at Kuakini, Children's, or St. Francis Hospital. Some of the students stated that "Careers Day" was the most worth while day they had in their lives. Many of the doctors who were hosts this year were repeaters from last year. Dr. John R. Stephenson was subcommittee chairman for medical careers day both for 1963 and 1964. It is proposed that the 3rd Annual Careers Day program take place on February 22, 1965.

On February 26, 1964, the Hawaii Medical Association, in cooperation with ancillary health associations, exhibited a booth on medical careers at the University of Hawaii under a twenty-foot banner labeled "Health Careers." The University of Hawaii started its annual careers day in 1963. Dr. Doris Jasinski was subcommittee chairman for the University of Hawaii Careers Day in 1963 as well as in 1964.

Three thousand Health Careers Charts were printed through a grant by the Honolulu Chamber of Commerce —1,300 of the charts were enclosed in the January-February, 1964 issue of the HAWAII MEDICAL JOURNAL. The remaining 1,800 will be sent to high schools, colleges, and to people who request them.

The Health Careers Chart gives in tabular form, the definition, preparation, required source of training, job opportunities, and rewards of 25 different occupations in the health field. There is a column indicating the source

where more detailed information may be gotten. Mimeographed information on separate careers was also prepared.

The Careers Committee feels greatly indebted to the Honolulu Chamber of Commerce for its support. Dr. Jasinski did much of the work in compiling the chart.

A projected endeavor of the Careers Committee is a Health Futurama. The Futurama would be an exhibit by different medical groups showing advances in medicine and giving the lay public some insight into the field of medicine. Internists could demonstrate the artificial kidney, electrocardiograms, etc. Orthopedists could demonstrate plaster casts. General practitioners could demonstrate first-aid techniques, use of stethoscopes, etc. Ophthalmologists could allow people to look into eye grounds of model eyes using ophthalmoscopes. Obstetricians, pediatricians, surgeons, and others could have exhibits of their choice. Such a futurama would not only help recruit prospective medical doctors but would also give the public a better image of the doctor.

The work of the Committee has been time consuming and arduous but the feeling of satisfaction gotten has been commensurate. The Committee would like to thank the Honolulu Chamber of Commerce, the Department of Public Instruction, the Vocational Counsellors, the University of Hawaii, The Queen's, Kuakini, Children's, and St. Francis Hospitals, the State Department of Health, and our own Hawaii Medical Association staff for making a difficult job pleasurable.

The Committee respectfully requests a budget of $370, the same as for 1963-1964. This does not include funds for a Health Futurama.

SAU KI WONG, M.D.

Careers Committee

Your Reference Committee next considered the report of the Careers Committee. A full and complete discussion of the subject was had.

Your Reference Committee feels that the Careers Committee has done an excellent job, and that the Committee's request for $370.00 be approved.

ACTION:

The Chairman moved adoption of this portion report. The wisdom of deleting the budget of the Maternal and Perinatal Mortality Study Committee and allowing $370 for careers promotion was questioned. It was noted that this committee could not function without funds and that the Maternal and Perinatal Mortality Study Committee could. It was adopted.

DISASTER COMMITTEE

The Committee held five meetings during 1963-1964. The Chairman took part in the annual AMA conference on Disaster Medical Care with a presentation of Hawaii's control center at Diamond Head and was represented at the monthly Health Service Coordinators Meeting.

Action was taken by the Committee with regard to chain-of-command responsibility in case of major disaster. It was decided that such planning and organization should be considered separately for and by each island or county, depending on local geographical and personnel factors. In general it was felt that the established line of authority vested in the offices of the county societies and the State Association, with Disaster Committee members acting in an advisory capacity, would best meet the requirements of any mass casualty problem.

Previous disaster care programs, with the exception of First Aid Stations on Oahu, have been continued. The Medical Self-Help Training program has taken the place of the latter for the time being and has been extended to all of the islands. The most recent development has been a start towards the inclusion of this training program in the curriculum of public as well as private schools throughout the state.

A doctors' radio call service has been successfully launched on Oahu with plans to extend its coverage to all parts of the island. This can eventually be expanded to include the major hospitals and will contribute greatly to the operation of any disaster plan.

A training program has been mapped for the utilization of the Civil Defense Emergency Hospitals which are prepositioned throughout the state. The Oahu CDEH training unit has been partially set up in a building at Fort Ruger and indoctrination courses will soon get under way.

A series of television programs on problems of first aid and medical self-help will soon be taped by the University of Hawaii. The format and content of this TV series was endorsed by the Committee and cooperation has been offered, with doctors participating in the production of 12 of the 14 video tapes.

Again it is recommended that once each year a program be devoted by each County society to the subject of disaster medicine and mass casualty care. Films and other training aids are available to provide interesting and worthwhile programs.

At a recent Council meeting the proper role of the State Disaster meeting was discussed. Each county has been asked to review its work in this area and make suggestions.

EDWARD W. BOONE, M.D.

Disaster Committee

Your Reference Committee feels that disaster is a local problem and can be best handled on the County level, but that a chairman of this Committee be retained on a State level as coordinator for the counties.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAIIAN ACADEMY OF SCIENCE

Eight physicians have agreed to be on the speakers' panel of the Inter-Society Scientific Education Committee, and will be listed in the Roster of Speakers, available for interested groups, especially in high schools.

A member of our Association was appointed to the Nominating Committee of the Academy. A physician was selected as one of the nominees for President-elect, and a physician was selected as one of the nominees for a vacancy on the Council of the Academy.

The customary $100.00 in annual support from the AMA was given and prizes were awarded to three student participants of the annual science fair. The awards were presented by Dr. West at the banquet which followed the close of the fair.

GRANT A. STEMMERMANN, M.D.

Hawaiian Academy of Science Committee

Your Reference Committee next considered the report of the Hawaiian Academy of Science Committee. No one appeared to discuss this report.

Your Reference Committee feels that this Committee's request for $100.00 toward the support of the Academy is justified and that the customary prizes amounting to $50.00 should be continued. It is recommended that this appropriation be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS COMMITTEE

This committee has had an active year. I feel the formation of subcommittees—TV-radio, Medical Message of the Month, News Media, and the Operation Pacific—has proved to be advantageous. Our activities this year have been successful for the most part; however, there

are several areas in which we have made no progress and other areas where we could have made more progress. Also, new ideas and new projects have come up which will be discussed later and proposed for your consideration for the next year.

The executive group, consisting of Drs. West, Allison, Nishigaya, plus Hugh Lytle, Lee McCaslin, and recently Bill Dodge, and I, has met weekly for Monday lunch. These have been productive meetings and I think they are necessary to keep our fingers on existing programs, as well as to treat new problems which occur almost daily. Our large Public Relations Committee meetings are held monthly. Reports from activities of the past month, plans for the oncoming month, and new policies and procedures were discussed. The following is a summary of activities of the subcommittees:

TELEVISION-RADIO COMMITTEE: Chairman Walter Chang is doing an excellent job. The active members on this committee were few, and most of the ground work was done by Hugh Lytle and Dr. Chang himself. We have not heard from the March Survey yet, however, the December survey gave us a 5 rating, which means that 5% of the TV sets (approximately 14,000) in the State were watching our program. The most popular program in Hawaii gets a rating of about 30. Our rating is the highest of any program on KTRG-TV. The newspaper articles during the week prior to the TV program have been very successful. Unfortunately, they have not been frequent enough, but it is sometimes difficult to convince the newspapers that a subject is exciting and dramatic. It is not always possible to think of a good gimmick to interest newspaper reporters in writing about a certain subject. Hugh Lytle is doing an excellent job. We have had considerable trouble in obtaining films for our programs. Many of the sources originally thought available did not materialize. Sometimes we have had to scramble to find films. Films made locally through the kind help of Dr. Liljestrand have only been partially successful, since we have not given him sufficient notice or time to do the best possible photography.

I should therefore recommend: (1) The HMA continue to seek a sponsor which would cut costs; (2) Coordinate the television program with the medical Message of the Month and News Media activities as much as possible; (3) Bill Dodge should gradually take over the leg work which Hugh Lytle is now performing, so that Hugh can be freer to work in the news media area. Hugh should continue to help edit the film, and use his experience in evaluating programs and chosing subjects and participants; (4) The audience demands dramatic film strips. I feel that more of these should be made locally with the help of Dr. Liljestrand and others who are adept in this field. For this, however, we need equipment. Each of these movies cost in the area of $30-40. I am asking for more money in this category in our new budget.

RADIO: The Ask Your Doctor program is doing extremely well. It has, at times, been difficult and time consuming for Hugh Lytle to prepare the programs. The doctors appointed to help him have been of some assistance. In the last two months we have coordinated the Ask Your Doctor program with the television program, and a participant on the Sunday night TV program has been used to tape the radio program for the next week. The education that Hugh Lytle has received from the TV program aids him in producing the radio program the following week. This program is of no cost to us and should be continued. At opportune times we continue to use Akuhead's morning program and Marion Sexton's noon program on which we place visiting professors or local doctors. This has happened frequently throughout the year, and we thank our doctors for being cooperative in appearing on these programs, sometimes on the spur of the moment.

MEDICAL MESSAGE OF THE MONTH: I believe this is an extremely successful project when you consider that for the cost of approximately $250.00 per month, about 140,000 messages get to homes via doctors' billings. Last year the major criticism for this program was its cost. We are happy to inform you that during the past year, four of the messages were paid for by organizations; i.e., Cancer Society, Heart Association, TB Association, and Eli Lilly. This year we hope to get further sponsorship and are pursuing ideas in that respect. Dr. William Moore has done an outstanding personal job in pushing this project. His personal contact with the doctors and the ladies of the Woman's Auxiliary who distribute the messages have been the main reason for the successful distribution. Without his constant attention this project would never have been possible. The ladies of the Auxiliary have been congratulated at the AMA-ERF dinner on April 18, and have been written personal commendations for their individual activity in this program. Through this program we were able to distribute our Kerr-Mills brochure. Messages were distributed through pay envelopes at many of the plantations through the cooperation and encouragement of the HSPA and Mr. Nelson Prather. The messages will continue to be distributed to plantations and gradually to more of them. I think this program should be continued. As the years go by it will become less expensive.

NEWS MEDIA COMMITTEE: Dr. Howard Liljestrand has done an excellent job in helping organize the activities of this group. When it was originally formed we were not certain of its function. The press luncheons held last fall were many more times successful than were expected. We received no criticism from the newspaper editors, and they were anxious to accept the offer of medical news and health education material from us. Immediately thereafter we were able to get three or four worthwhile articles, the outstanding one of which was the half-page spread on anesthesiology just prior to our TV program on the same subject. We were slow in starting the weekly articles, but the newspapers have now received three. To our pleasant surprise the *Advertiser* has started printing them on a weekly basis. The weekly papers are using them also. We have not yet started a question-answer-Dr. Molner-type column requested by the weekly papers, but plan to in the near future. We have been most successful with information given to reporters just prior to a TV program to publicize the program, and will continue to seek this coordinated coverage of health and education material in the newspapers. I personally feel that our efforts to be cooperative with the newspapers and to give them material has improved their cooperation with us. I mention, for example, the recent Children's Hospital publicity, and the Kerr-Mills brochure rhubarb. Had this occurred two years ago, I think we would have fared much less well.

OPERATION PACIFIC: Approximately one year ago American Samoa obtained enough doctors to become relatively self-sufficient. The call for doctors to go to American Samoa practically stopped. We wrote to Western Samoa to start a project of a similar nature there. We have received no answer from them. When there was a need, several doctors have gone to various South Pacific islands in the past year; e.g., Canton Island. This was done through their own arrangements, and not through the HMA. One month ago I called a meeting and included many of the individuals who participated in Operation Samoa. We discussed the successful Samoa project, and decided to make a new attempt to find a project in the Pacific area. Letters have been written to Prince Tunia in Western Samoa, and to Apia, offering our help in their medical program, mainly from the educational standpoint. It is felt that financial help from local foundations might be possible. Dr. Thomas Richert has offered to continue to chair this group, which I hope will become active again.

KERR-MILLS BROCHURE: After six months of preparation, our Kerr-Mills brochure was finally completed. It was sent out as a medical message of the month at the end of February. We expected opposition to this pamphlet although it was designed to be strictly educational and nonpolitical. We were surprised to hear very little objection to it. A group of doctors interested in the Kerr-

Mills Law met three Tuesday mornings for breakfast and Hugh Lytle helped us educate ourselves on the subject in case it would be necessary to defend ourselves regarding the medical profession's stand on the Kerr-Mills–King-Anderson situation. Nothing appeared in newspapers after distribution of the brochure. What finally did appear in the papers sometime later through the courtesy of William Among, I believe in the end definitely helped our stand.

GILL-ANNIS DEBATE: We are happy the letters regarding the Gill-Annis debate were made public. We hope our final letter got across to those opposed to our Kerr-Mills brochure and that they recognize we are merely seeking to educate the people of Hawaii on this subject, and that we are encouraging a debate between Gill and Annis on an educational basis, not for any political reason. We are still attempting to schedule a Gill-Annis debate the first few days of June, but Mr. Gill appears reluctant to meet Dr. Annis.

ANNUAL MEETING DISPLAY: This year we will have a booth at the annual meeting showing the public relations projects of the past year. Hugh Lytle and Bill Dodge will be present between scientific sessions to explain the program to doctors and to take their suggestions and criticisms. There will be some pictures on the Health-O-Rama held in Miami, Florida, as well as some information regarding the Health Futurama held in San Diego. I believe this type project has good public relations value, and should be considered as a future project in Honolulu.

ASSOCIATION OF PROFESSIONS: This has operated as an ad hoc committee for several years. It has not been active and little has been accomplished. I recommend that the ad hoc committee be dissolved and this project become the responsibility of the Public Relations Committee.

NEIGHBOR ISLANDS: Last fall I made a trip to each county to attend society meetings, and explain our public relations program. I had the feeling that these visits were successful and helped justify our public relations program as it affects doctors on the neighbor islands. Also an attempt to include the neighbor islands in the program was made in January when we paid for airplane tickets to bring one doctor from each county to a monthly PR meeting. This meeting was held at the International Airport for their convenience. I believe a meeting of this sort is indicated on an occasional but not regular basis. Visits to neighbor islands by HMA officers have helped immensely in disseminating information and getting opinions re HMA policy.

HEALTH POSTERS: It was felt that the health posters and pamphlet racks available through the AMA are excellent. We have encouraged doctors to have pamphlet racks in their offices, but we have only been partially successful. We have accomplished nothing with the posters, but have ideas. I believe both these projects can be areas of endeavor in the coming year.

In conclusion I think our active public relations program is bearing some fruit. We certainly have a long way to go. I wish to thank all delegates and all members of the Association for their cooperation and generosity in granting our budget requests this past year. I am happy to say we have money left over. Our budget for the coming year can be estimated on a more realistic basis due to our experience in the past year, and I submit the following budget (which is $2,360.00 less than requested for 1963-64) for your consideration.

Conference Expense	$ 480.00
Counsel	6,000.00
Miscellaneous Newspaper Ads	500.00
MESA Dues	10.00
Miscellaneous Flyers	.....
Miscellaneous Printing	350.00
Miscellaneous	50.00
Message of the Month	2,000.00
Press and Other Entertainment	200.00
Photo Costs	100.00
Press Awards	110.00
Radio	.....
Special TV Programming	1,000.00
TV Programs	
Sunday Ads	600.00
Daily Ads	.....
Moderator	1,040.00
Special Films	500.00
Postage	100.00
Miscellaneous	30.00
Travel	500.00
Total	$13,570.00

The following is an explanation of certain items in the public relations committee budget:

Newspaper Ads: I feel only $500 is necessary this year. The large budget last year was for the purpose of political newspaper ads which were found unnecessary but may be helpful in November.

Miscellaneous Flyers: The $400 was for the Kerr-Mills brochure which is now complete. No further brochures are contemplated.

Printing: This budget is for miscellaneous printing, such as advertisements for TV programs in doctors' offices, or posters in doctors' offices regarding socialized medicine, etc. We have some plans in this category.

Message of the Month: This past year each message cost approximately $250 to print. Four of the messages were paid by other organizations. Therefore, the amount budgeted could be cut to $2,000.

Press and other Entertainment: This was for the press luncheons which were found successful and should be repeated. $200 is sufficient for this purpose.

Photo Costs: $100 is necessary for miscellaneous photos, such as pictures taken by Hugh Lytle for display at the annual meeting, visitors coming into the airport, etc.

Press Awards: The additional $10.00 is for the silver cup award.

TV Program: The $1,000 budgeted was to finance the Annis-Gill debate. At this time we do not know whether or not it will come off in June. If it does not we will probably push it again in the fall. I therefore think that if this amount is not used this year, it should be rebudgeted for next year.

Special Films: As I mentioned in my TV Committee report, I believe we should take more special films of surgery, etc., in Honolulu for our TV programs. Therefore, the allowed budget last year of $400 has been raised to $500.

Thank you for considering this budget.

ANDREW C. IVY, JR., M.D.

Public Relations Committee

Your Reference Committee next considered the report of the Public Relations Committee. A full and complete discussion of the subject was had.

Your Reference Committee feels that the Public Relations Committee has done an excellent job throughout the year and recommend that the budgetary request be granted as requested.

The Chairman recommended that in view of the previous action of the House in cutting this budget that the last three words be deleted and the following inserted "be reduced."

ACTION:

Mr. President, I move adoption of this portion of the report.

Some of the Delegates felt that it was imperative that $2,480 not be reduced from the Public Relations budget.

It was moved that we amend the motion of deleting this portion which recommends that

the sum of $2,480 be deleted from the Public Relations Committee. The motion failed to carry.

The importance of this Committee was brought out. It was suggested that the Committee ask the Council for more money when they need it or come back to the House of Delegates' interim meeting for additional funds.

It was moved that the report be approved with the amendment that if the Public Relations Committee needs additional financial support that it be encouraged to return to the Council to obtain these funds. The motion was carried.

This portion of the report as amended was adopted.

PUBLIC RELATIONS COUNSEL

Two years ago I took the liberty, as a layman, of suggesting that doctors of Hawaii take part in greater numbers in public education activities of the Hawaii Medical Association. The result surpassed expectations.

Since that time no less than 156 local physicians have taken part in the live, weekly television program "Call The Doctor," presented every Sunday at 9 P.M. over KTRG-TV. The station provides public service time and cooperates with the profession in every way. Nearly 100 programs have been presented and some of the doctors have appeared several times each. Popularity of the television program has grown and although KTRG has difficulty in reaching some areas, it is estimated that 14,000 families now listen regularly and usually flood the telephone lines seeking answers to questions.

The television show, in conjunction with the weekly radio program, "Ask The Doctor," presented every Wednesday at 7:05 P.M., over KGU, also on public service time, gives a broad exposure of medical and health matters of which physicians may be proud.

Wider coverage is evident in newspapers as well. A half-dozen newspaper writers have developed an interest in medical reporting during the last two years. This is due, in part, to the prize contest conducted by the Hawaii Medical Association. Each year the Association presents $100 in cash and a silver bowl for the best medical reporting of the year.

There is increasing cooperation with the press by doctors and hospitals. For the first time a *Star-Bulletin* reporter and photographer were allowed to make a picture story in an operating room at The Queen's Hospital and produced an exceptionally good article on anesthesiology. Others are in prospect. Other hospitals have extended similar cooperation.

These are in addition to normal releases made by the Asscciation in matters of health and medicine. Samples of some of this reporting will be shown at the 108th annual meeting of the Hawaii Medical Association along with a display of other PR projects.

If physicians will take as much interest in the Speakers Bureau as they have in radio, television, and the press, most of the bases will have been covered so far as public education is concerned.

In closing, may I say that the regular and dedicated work of the Woman's Auxiliary in distributing the valuable Message of the Month has made that endeavor a success. Without them it would have been impossible.

HUGH W. LYTLE

Public Relations Counsel

Your Reference Committee next considered the report of the Public Relations Counsel.

Your Reference Committee feels that Mr. Hugh Lytle has done an excellent job and that his services should be retained.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MESSAGE OF THE MONTH SUBCOMMITTEE

The Committee held monthly meetings at 7:00 p.m. on the first Tuesday of the month, and prepared messages covering the subjects which were distributed in the month indicated below. Subsidies were provided for four of the messages from the organizations indicated in brackets. This resulted in a considerable savings and permitted the Association to use part of this budget to print sufficient Kerr-Mills Flyers to make a complete distribution.

The following Messages have been published to date:

June, 1963—Parents of School Age Children
July, 1963—Sunbathers and Outside Workers
August, 1963—Those Who Smoke but Want to Stop (Cancer Society)
September, 1963—Those who Want to Check Their Immunization Records
October, 1963—Those Concerned About Diabetes (Eli Lilly)
November, 1963—People With Potential Chest Problems (TB Association)
December, 1963—All Our Members' Patients
January, 1964—All Hearts Young and Old (Heart Association)
February, 1964—Kerr-Mills Flyer
March, 1964—People With Overweight Problems
April, 1964—People Who are Concerned About Mental Health

It should be noted that beginning with the Kerr-Mills distribution in February, a number of plantations joined in this project and ordered flyers to give out to their employees. The average distribution amounts to 140,000 and costs have been brought down to just under $250.

A new policy of coordinating the Message with the TV program that is produced at about the time the flyers are distributed gives added impact. The April flyer is on mental health and the April 26 TV program will be on the same subject. The May flyer will be on arthritis, which will be paid for by the National Foundation, and the May 31 TV program will be on the same subject. The Tuberculosis & Health Association has agreed to subsidize the November flyer each year provided they will be consulted on content. They would also like to have their trade mark incorporated in the flyer. The National Foundation has made a similar request but this matter has not yet been presented to the committee for discussion.

The principal problem continues to be distribution. We have been fortunate in having the services of some very loyal members of the Woman's Auxiliary who faithfully pick up and distribute the flyers each month. Regrettably the number of willing workers has not been quite sufficient to meet our needs. Neighbor island distribution has been made by mail.

Some of the 31 original volunteers from the Woman's Auxiliary have had to drop out, but we hope to recruit replacements.

The project continues to gain momentum and public interest and I feel that it has been worth all the hard work involved in getting it started and keeping it going.

WILLIAM F. MOORE, JR., M.D.

Message of the Month Subcommittee

Your Reference Committee next considered the report of the Message of the Month Subcommittee.

Your Reference Committee feels that there should be an austerity program and that the subcommittee should as much as possible seek financial commitments from outside agencies.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEWS MEDIA SUBCOMMITTEE

The subcommittee was instructed to explore the relationship between the Hawaii Medical Association and the press and to learn what steps should be taken to improve the rapport.

Accordingly, a series of conferences were held with representatives of the two major newspapers and the various wecklies. These conferences were most cordial and instructive. The daily papers, basically, asked that we do what we could to help them dramatize the truth. The weekly papers are less interested in dramatization of the truth of day-to-day news, than they are in feature type material, such as a weekly column which might develop into the addition of questions and answers.

An attempt was made through the committee to develop material for these purposes. The results were weak simply due to lack of response of the committee members, even in so minor a thing as composing a few questions, not to mention the development of entire articles.

The problem now is apparently solved through staff action, so far as the weekly story is concerned. The mechanism is as follows: The weekly story is tied in with the weekly radio and TV programs. When interviewing the physician for the radio program, Hugh Lytle tapes the interview. Subsequently, he revises and rewrites this interview and cuts it to newspaper length. This has worked well for several weeks now and newspaper acceptance has been excellent. They have credited HMA with the information. So far, I am pleased with this facet of our activity.

Queries from the press are coming in frequently, almost daily. This is gratifying as an indication not only of interest but of awareness on the part of the reporters that the HMA and our public relations counsel are available and functioning.

There has been a big increase in volume of medical writing in the newspapers. This can probably be ascribed partly to the Association annual prize for the best press writing. This has evidently generated interest and competition. Prizes will be displayed and awarded at the HMA Convention.

A clipping service is now being utilized. This serves a number of purposes but the disposition and classification of the clippings probably could be further improved.

SUMMARY AND RECOMMENDATIONS: Press relations at present are excellent. The volume is high and increasing. This is thanks to the efforts of the public relations chairman, Dr. Ivy, who is spending large amounts of time and energy on this project; and due to the successful efforts of the public relations counsel, Hugh Lytle. It is urgent that he continue to be encouraged in every way, particularly by the provision of all necessary equipment, such as a good tape recorder.

It should be doubly emphasized that for the success of this program we are heavily dependent upon the staff. Our physician members serve excellently when called upon for specific projects but they cannot be expected to take the time to produce press material on a continuing basis. Our try in this direction resulted in failure. The staff, on the other hand, is carrying out the assignment well. Therefore, I would like to emphasize again that it is vital that Mr. Lytle and the staff be encouraged in every way.

P. H. LILJESTRAND, M.D.

News Media Subcommittee

Your Reference Committee next considered the report of the News Media Subcommittee.

Your Reference Committee feels that the report of the Committee should be accepted as a whole.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TV-RADIO SUBCOMMITTEE

The Sunday hourly television program from 9:00 P.M. to 10:00 P.M. has become one of the most popular, if not the most popular, program on Channel 13, KTRG-TV. Mr. Hugh Lytle, the producer, and Mr. Gordon Burke, the moderator, deserve praise for their fine work. Without the excellent cooperation of many participating physicians and the hard work of the committee members, the program would not be the success it is now. However, some method of procuring a steadier supply of visual aids, movies in particular, should be worked out. Otherwise, the program has functioned very smoothly during the past year.

WALTER Y. M. CHANG, M.D.

TV-Radio Subcommittee

Your Reference Committee next considered the report of the TV-Radio Subcommittee.

Your Reference Committee feels that the Chairman of the Committee has done an excellent job throughout the year and that the report be accepted as a whole.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

Reduced to a spun caduceus of significantly tiny indices the Woman's Auxiliary to the Hawaii Medical Association summarily presents a chronicle of the year's activity. This wondrous complex that is the Hawaii Auxiliary, with the cadence borne of the vitality of the youngest state in the union, has much to say in deeds. In truth, the deeds stand tall and cast their own shadows.

At the center of this burgeoning insistence of a story of medicine the impact of the International Health Activities of the Honolulu County Auxiliary was felt on a little land-locked Southeast Asian country—Laos. In the wake of a direct appeal of the Public Health Advisor to the Royal Laotian government, serving with the U. S. Aid Program, the members of this Auxiliary in empathic concern for the welfare of others undertook the monumental task of collecting, sorting, and packing 117 cartons of clothing and (to date) 46 cases of canned milk. In this heyday of complicated red tape the resourcefulness that is woman equated need with speed. Recounted with utter simplicity, the mighty United States Air Force with heartening dispatch accepted this cargo bound for Laos, space available.

In the area of civil defense the story of medicine had been repeatedly injected in the periphery of awarenss of, and attention to. The efficient state chairman of the Civil Defense Committee recruited other Auxiliary members in an effort to assist in training literally hundreds and hundreds of individuals in the community re medical self-help. Now, in this year of 1963-64 through the direct efforts, persistence, and energy of this Committee the State Board of Health Civil Defense Agency implemented, for the first time, a medical self-help program in the public and private schools.

Public relations is the art of interpretation, the art of communication; its approach—positive; its goal—understanding. A public relations and communications program has been implemented by the doctors with the help of the Auxiliary in accomplishing this objective. More than 65 Oahu doctors' wives call on each physician monthly in an all-island distribution of provocative health tips or medical messages of the month destined for dissemination to the physicians' patient. (These messages number conservatively in excess of 140,000 per month.)

With a constructive and positive posture the Hawaii Medical Association assumed the task of leadership manfiest in the career guidance of emerging men of medicine. To orient potential medical students in the province of medicine the doctors enlisted the aid of the

Auxiliary in formulating the program of Medical Careers Day. Told the story of medicine were academically qualified Junior and Senior students (selection thereof predetermined by 28 public and private schools counsellors). The auditory, visual, and kinaesthetic approach of lectures, exhibits, demonstrations of kidney machine, operating procedures, etc., were geared to activate the imagination and lengthen the perspective of these students who evidenced a serious interest in medicine. We view with pride the efforts of the HMA for its inspiration and stimulation of the first stirrings of these young minds.

Holding to a coherent accent to serve and communicate in the mart of human relationship the continuing priority project of aid to medicine via AMA-ERF assumed a whimsical and capricious note in Honolulu. "Fun and Fashions for Funds" presented a faultless selection of high fashion attire for the Doctor and his lady—modeled by the Doctors and their ladies. Approximately 450 physicians, their wives and guests gathered in the Princess Kaiulani Hotel for cocktails, dinner, and the fashion show.

The 650 plus members of the Hawaii Auxiliary are divided into three organized counties and one group of members at large. Because of the density of population on the island of Oahu, this Auxiliary has eight times the numbers of members as the next largest group. Therefore almost all activities must be credited to the very active and able Honolulu County Auxiliary. On the neighboring islands—Kauai, Maui, and Hawaii—the measure of community and medical activities, despite the small membership, is appalling in its many-faceted intensity . . . among the many community activities we enumerate a fraction thereof . . . Board of Trustees Library Association; Library Board Commission; Community Chest, Board of Directors; Rehabilitation Center, Board of Directors; Philharmonic Board, Housing Committee; assisted with Blood Bank, T.B. Skin Testing, Glaucoma Clinic, Diabetes Detection Survey, State Tumor Survey, etc.

The task confronting us as Auxiliary members required and requires comprehension of the issues, a clear definition of goals and commitment to them consistent with a purpose staunchly held . . . a story lucidly told. Add to this a measure of strength, wisdom, and values related to and gaining perspective from the broad canvas that is medicine and there emerges in crystal focus the inherent worth of a united colleagueship of Doctors' wives in Hawaii.

MRS. HERBERT G. PANG

Woman's Auxiliary, Hawaii Medical Association

Your Reference Committee next considered the report of the Woman's Auxiliary, Hawaii Medical Association. There was no one to appear to discuss this report.

Your Reference Committee feels that this report is excellently written.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY ADVISORY COMMITTEE

Neither the Committee nor the chairman was called upon by the Auxiliary for advice or consultation, and so no meetings were held.

A. L. VASCONCELLOS, M.D.

Woman's Auxiliary Advisory Committee

Your Reference Committee next considered the report of the Woman's Auxiliary Advisory Committee. No one appeared to discuss this report.

Your Reference Committee feels that this report should be accepted as a whole.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 7

Re: Opposition to the Nationalization of Medicine

WHEREAS, The House of Delegates of the American Medical Association in June, 1963, called for a re-evaluation of its previous endorsement of "bricks-and-mortar" federal aid, and

WHEREAS, Evaluation of the Public Health Service Act (1944) and subsequent additions and amendments thereto —beginning with Hill-Burton Act of 1946 and continuing through the present Harris proposals (HR 10041 and HR 10042)—lends credence to the opinion that all these acts are part of a steadily evolving plan to accomplish the Nationalization of Medicine attempted earlier by the discredited Wagner-Murray-Dingell bills, and

WHEREAS, The ruling of the United States Fourth Circuit Court held that acceptance of Hill-Burton funds by private hospitals puts such hospitals into a Federal-State public health program and makes them a part of "State action"; and therefore be it

Resolved, That the House of Delegates of the Hawaii Medical Association hereby reaffirms its continuing opposition to "bricks-and-mortar" federal aid; and be it further

Resolved, That the House of Delegates of the Hawaii Medical Association urgently calls upon the House of Delegates of the American Medical Association to thoroughly re-evaluate its conflicting stands regarding federal aid and to come out with a statement based on principle in strict opposition to all proposals which may lead to the Nationalization of Medicine, regardless of the route such proposals may take.

Submitted by F. J. PINKERTON, M.D.

Resolution No. 7

Your Reference Committee considered the resolution on opposition to the nationalization of medicine. Dr. F. J. Pinkerton was called on to discuss this resolution. A full and complete discussion of the subject was had.

ACTION:

The Chairman recommended that this resolution not be adopted. It was not adopted.

The Chairman moved the adoption of this report as a whole as amended. It was adopted.

UNFINISHED BUSINESS

It was suggested that a fifth reference committee be appointed so that there is no conflict regarding the budget of the various committees.

Dr. Tomita asked permission to present a resolution of thanks.

ACTION:

It was moved to permit Dr. Tomita to introduce a resolution. The motion was carried.

RESOLUTION NO. 9

Re: Dr. Felix Marti-Ibañez

WHEREAS, Dr. Felix Marti-Ibañez has again this year wholeheartedly shown his support of the Annual Medical Careers Day Program; and

WHEREAS, He has kindly contributed both the prizes and warm letters of congratulations to the winners; and

WHEREAS, The Careers Committee feels the support Dr. Marti-Ibañez has given to the Careers Program is greatly appreciated; now therefore be it

Resolved By the House of Delegates of the Hawaii Medical Association, 1964 Session, that its gratitude and thanks be extended to Dr. Marti-Ibañez and that he respectively be requested to continue to serve as an

inspiration to the students of Hawaii, indeed, to students everywhere, and be it further

Resolved, That a copy of this resolution be sent to Dr. Felix Marti-Ibañez.

Submitted by THEODORE T. TOMITA, M.D.

ACTION:

It was voted to adopt this resolution.

Dr. West asked how the Delegates felt about having Dr. Nils P. Larsen's art exhibit packed and crated and sent to the Physicians Art Exhibition in San Francisco and paid for by the Hawaii Medical Association.

ACTION:

It was voted to have the Hawaii Medical Association pay for the packing and crating of Dr. Larsen's exhibit and send it to the AMA Physician's Art Exhibition in San Francisco.

NOMINATING COMMITTEE

The Nominating Committee met and selected nominees for officers to be elected at the annual meeting.

The Committee reviewed, studied, and discussed the qualifications of many candidates and is pleased to present the following slate of nominees for your consideration. All nominees have agreed to run and have promised to faithfully fulfill their duties if elected.

President-Elect.....O. D. Pinkerton
Secretary.....Randal A. Nishijima
Councillor from Hawaii.....Robert M. Miyamoto
Councillor from Maui.....Joseph E. Andrews

The Nominating Committee was charged by the President to nominate members for the 1964-65 Nominating Committee, five from Honolulu and one from each of the other three counties. However, after reviewing the Bylaws, the Committee decided it was not incumbent upon them to do this and that nominations for the Nominating Committee should be made from the floor of the House of Delegates.

The Bylaws, as they relate to the Nominating Committee read: A Nominating Committee of eight (8) members shall be elected annually by the House of Delegates at the Annual Meeting. Five members shall be from Honolulu County and one each from the other three counties. The Committee shall elect its own chairman. Its duty shall be to make the needed nominations for the election of officers at the next Annual Meeting.

The Committee wishes to advise that it felt that there should be two candidates for the office of President-Elect. Two members were asked to be candidates, but one of the prospective candidates declined the nomination.

Dr. Pinkerton's election to the office of President-Elect will leave a vacancy in the Council and a member of the Honolulu County Medical Society will have to be elected to complete his term.

RICHARD D. MOORE, M.D.

ACTION:

After nominations from the floor were solicited, it was voted to accept the slate by acclamation and instruct the Secretary to cast a unanimous ballot.

After receiving Dr. Pinkerton's resignation as Councilor from Honolulu County, the President requested nominations from the floor for a Councilor to complete the final two years of his term. Drs. Theodore T. Tomita and A. S. Hartwell were nominated.

The President asked for nominations for the Nominating Committee for 1964-65. The following nominations were made from the floor: Drs. R. F. Shepard, Allan Leong, Robert T. Wong, Richard D. Moore, Robert M. Miyamoto, Marvin A. Brennecke, Frederick L. Giles, William W. L. Dang, Grover H. Batten, M. H. Chang, Clifford F. Moran, Yonemichi Miyashiro.

Drs. Ralph M. Beddow, R. P. Wipperman, and Marion Hanlon were appointed tellers.

The results of the election were announced as follows:

President-Elect.....*O. D. Pinkerton*
Secretary.....*Randal A. Nishijima*
Councilor from Hawaii.....*Robert M. Miyamoto* (three years)
Councilor from Maui.....*Joseph E. Andrews* (three years)
Councilor from Honolulu.....*Theodore T. Tomita* (two years)
Nominating Committee.....*William W. L. Dang*
Allan Leong
Richard D. Moore
R. Frederick Shepard
Robert T. Wong
Robert M. Miyamoto (Hawaii)
Marvin A. Brennecke (Kauai)
Clifford F. Moran (Maui)

The meeting was adjourned at 6:00 P.M.

RANDAL A. NISHIJIMA,
Secretary

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cohol addicts to every drug addict. **Dr. Walter B. Qnisenberry** has recently been named to the Advisory Council for a three-year term.

Ten million dollars in funds will be poured into a five-year research program seeking "chemical persuaders capable of inducing the body to manufacture cancer-fighting weapons." Six major American tobacco companies will contribute the lion's share of the money . . . a fight for their life!

CMA and other professional associations in California have issued bulletins urging every user to review procedures for disposal of unused, partially used, or used drugs, syringes, and other biological products which can be picked up by children from refuse cans.

Sad Notes . . .

Gone was $62.00 in cash from the home of **Dr. Clarence M. Burgess.** Burglars did the work by breaking into his home.

About $120.00 was stolen from **Dr. Warren Olanow** at The Queen's Hospital interns' quarters.

Isle co-ed Diane Elizabeth Halpern, daughter of **Dr. and Mrs. Gilbert M. Halpern** was killed in a light plane crash in Wyoming.

Dr. Dorothy Hope Kemp, former Director of the Territorial Health Department, Division of Hospital and Medical Care, died at The Queen's Hospital after a long illness. She was 56. ■

County Society News *continued from 479*

measurable characteristics in connection with a heart disease control program.

Members of the Kauai County Woman's Auxiliary were invited to the May 5 meeting. Special guests were Mesdames Mary Cooper and Arlene Young, of the American Red Cross, and Dr. and Mrs. C. Rodney Stoltz.

After the proposed Red Cross mother-and-baby care course was discussed, it was voted to give the program official approval and support.

Dr. Wade reported that no new or important business transpired at the HMSA Medical Committee meeting which affected Kauai. Dr. Kim reported on the HMA House of Delegates meeting. Dr. Boyden transmitted the thanks of two of the students who had been sent to the Careers Day program in Honolulu.

After a discussion on a letter received from the HMA Communicable Disease Committee, it was voted to send a letter to Dr. Bernstein unanimously approving the recommendation for the use of Polio Vaccine III.

It was voted to accept the offer of Dr. R. J. Rose of the Veterans Administration to appear before the Society to discuss veterans' benefits. Visiting professor Dr. Henry T. Bahnson will be invited to address the Society on August 8.

A letter from Dr. Felix regarding the Wednesday afternoon scientific session scheduled for Kauai in connection with the 2nd Hawaii Medical Seminar was read and it was voted to suggest that the time of the session be changed to avoid conflict.

It was voted to approve and support the resolution entered by the Hawaii County Medical Society and adopted at the HMA annual meeting which asks for exemption of radiologists, pathologists, and anesthesiologists from civil service status in government hospitals. ■

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mology, the *Laryngoscope* and the *New York Medical Journal and Record.*

For the part he played on the morning of Pearl Harbor December 7, 1941, Dr. Morgan was awarded a letter of commendation from the Commander-in-Chief of the U. S. Pacific Fleet.

His interest in, understanding of, and sympathy for the nursing profession was deeply sustained throughout his professional life. Among his most treasured possessions was a handsomely tooled leather portfolio inscribed:

Dr. James A. Morgan
First
Honorary Member
Nurses' Association
Territory of Hawaii
in recognition of his
distinguished service
and valuable assistance
to the nursing profession
1946.

Dr. Morgan died September 25, 1951, in his home in beautiful upper Nuuanu Valley at the age of 74.

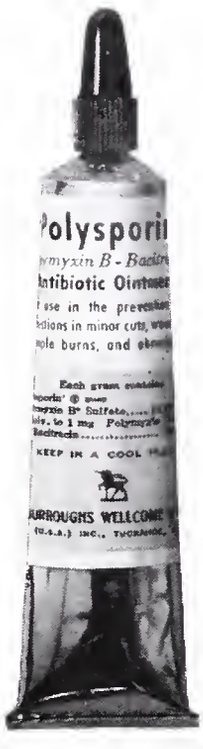
He was a trustee of the Board of Directors of the Protestant Episcopal Church of the Hawaiian Islands. He served on the vestry of St. Andrew's Cathedral and took an active part in the growth of St. Mark's, Kapahulu. He was a member of the Board of Governors of Iolani School and a member Board of Managers of the Army and Navy Y.M.C.A.

Dr. Morgan was a Fellow of the American College of Surgeons, a member of the American Medical Association, Territorial and County Medical Societies of Hawaii and Honolulu, American Academy of Ophthalmology and Otolaryngology, Pacific Coast Oto-Ophthalmological Association, and the American Association for the Advancement of Science. He was a member of the Board of Trustees of The Queen's Hospital, life member of The Queen's Hospital Corporation, Secretary of the Board of Medical Examiners, and Secretary of the Board for the Licensing of Nurses.

He was an honorary member of the Rotary Club, Chamber of Commerce, a Mason, member of the University and Oahu Country clubs, and of the Massachusetts Society of Mayflower Descendants. ■

MRS. JAMES A. MORGAN

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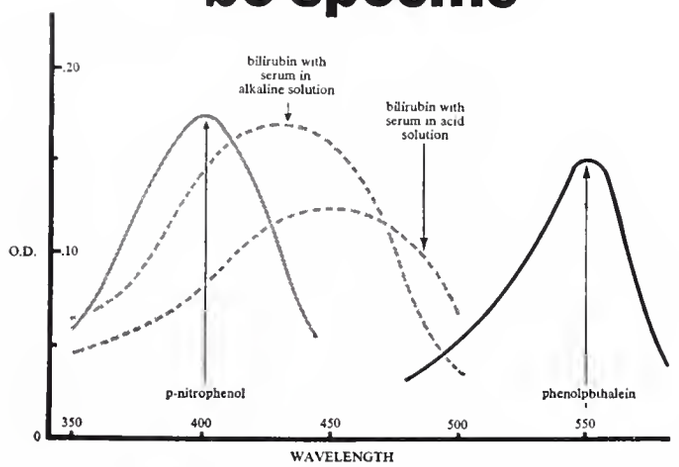
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1. Klein, B.; Read, P. A., and Babson, A. L.: Clin. Chem. *6*:269, 1960.
2. Babson, A. L.: Am. J. Med. Tech. *28*:227, 1962.
3. Gambino, S. R.: Critique—Alkaline Phosphatase; reported by the Commission on Continuing Education of the A.S.C.P., December, 1963.
4. Babson, A. L.; Read, P. A., and Phillips, G. E.: Am. J. Clin. Path. *32*:1, 1959.

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GENERAL DIAGNOSTICS DIVISION WARNER-CHILCOTT DIV. MORRIS PLAINS, N.J.

HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: JAMES YANO, Kaiser Foundation Hospital

President's Message

With the end of my term in office as president of the Hawaii Society of Medical Technologists for 1963-64, I would like to take this final opportunity to express my sincerest appreciation for the loyal support you have given me throughout the entire year. I have been well aware that any success realized during my administration could only be attributed to the fine cooperation and hard work of the organization, the executive committee, all of the standing and special committees, and the faithful members of our group.

Let me reminisce for a moment upon some of the interesting and significant events that have occurred over the past year—the picnic at Ala Moana beach for the interning students, the successful candy sale during Christmas to raise enough funds to send our President-elect to the annual convention in Kansas City and for the scholarship fund, the donation of the two volume edition of *Clinical Laboratory Method and Diagnosis* by Gradwohl to the Hawaii Medical Library, the impressive workshop on instrumentation so expertly done by Mr. Charles Humes of Coleman Instruments, Inc., the final banquet at the Willows restaurant—all of these memories bring me a feeling of satisfaction. It was indeed a pleasure to have been of service to our society during the past year and I am most grateful for the opportunity.

In closing, may I ask that you continue your fine support with the next administration headed by our incoming President, Mr. Kenneth Sato. My best wishes to the incoming officers and committee heads.

Mahalo, JACK FURUTA

HSMT Officers for 1964-65

Congratulations are in order for the newly elected officers of the Hawaii Society of Medical Technologists for the coming year. To lead the Society in a vigorous year of activities, we have our President, Mr. Kenneth Sato. Other officers include Miss Edith Eckstein, President-elect; Miss Jean Nishimura, Corresponding Secretary; Miss Mabel Kimura, Recording Secretary; Mr. Kaname Saito, Treasurer, and Director, Mrs. Alice Tonchon.

We are reminded that the success of any organization, with its numerous duties and responsibilities, rests upon every member of the organization, and not solely upon the officers. Let us give our unselfish support and efforts to each undertaking contemplated for the coming year.

Medical Technologist Interns for 1964-65

We are happy to announce the following assignments of medical technologist interns to the various approved teaching hospitals in Honolulu for the year. Kaiser Hospital has Clarie Fukushima and Roy Ohye; Kuakini Hospital has Irene Matsuo and Ethel Naito; and The Queen's Hospital has Leah Taga and Marian Takehara. Interning at St. Francis Hospital are Noreen Kawamura, Judith Nitta, and Lillian Uemori. At Tripler we have Joan Cunningham, Patricia Dennis, Sandra Fullreader, Takeko Iha, Eleanor Kamada, Wendell Lyon, Vickie Nojima, William Scholdt, Irene Teruya, and Carol Titsworth.

The HSMT would like to extend a cordial welcome to the field of medical technology and to extend a special invitation to attend our first general meeting for the year sometime in August. The demand for good, well-trained medical technologists is great; therefore, serve your internship period with much zeal, with seriousness of purpose, and with pride.

National Convention in Kansas City

"Launch Into Tomorrow" was the theme chosen for the 32d annual convention of the American Society of Medical Technologists held in Kansas City, Missouri, June 14-19. The official delegates to the convention were our newly elected president, Mr. Kenneth Sato, and the instructor of medical technology at the University of Hawaii, Mrs. Louise Wulff.

The following medical technologists were elected to serve as officers of the ASMT for the coming year: President, Jeanne L. Schlafman; President-elect, Anna Fagelson; Recording Secretary, Kathern Forest; Board of Schools, Ruth Williams; Education and Research Fund Board of Director, Esther Misterek; and two elected to the Board of Directors, Doris Ross, and Sarah M. Cicarelli.

Among the principal speakers of the huge convention were Dr. Raymond Gambino of Englewood, New Jersey, who spoke on chemistry, and Dr. John Lang, a lecturer in education and psychology at George Washington University, who conducted a series of lectures on "Supervision—a Medical Technologist's Responsibility." Dr. Dennis Dorsey from Danbury, Illinois, held a workshop on "Quality Control in Hematology." Dr. Russell Eilers of Kansas University Medical School presented a paper entitled "The Lost Art of Urinalysis." Dr. Curt Riseman of Kansas University Medical School gave an interesting presentation on space medicine.

Two Hawaii technologists were honored at the national convention with Louise Wulff receiving the Corning Award for being the Hawaii technologist for the year and James Yano receiving honorable mention in the color photo contest.

More news and highlights of the convention will appear in our next issue of the *Bulletin*.

Reminders

Please submit your national and state dues, $12.00 for the national and $6.00 for the state, to our Treasurer, Mr. Kaname Saito, in care of Straub Clinic, Laboratory Department.

Scientific manuscripts or papers written by our members should be submitted to our Editor at any time. This is one of the prime purposes for our section of the JOURNAL.

Abstract

"Amniotic Fluid Analysis in Prenatal Diagnosis of Erythroblastosis Fetalis"—Harold R. Misenhimer, Capt. (MC), USAF; J. of OB-GYN 23: 485-493, April, 1964.

"In 1950, Bevis, in England, began to study the amniotic fluid of Rh-isoimmunized patients in an attempt to find an accurate diagnostic aid for predicting the degree of fetal involvement. By 1961, Liley, in New Zealand, had published an account of his experience in the use of spectrophotometric analysis of amniotic fluid for the management of this problem. He was highly successful in predicting both degree of involvement and in planning time of delivery.

"An attempt is made to obtain amniotic fluid specimens by transabdominal amniocentesis from all Rh-negative patients in whom there is evidence of isoimmunization. Whenever possible, the first specimen is obtained between 30 and 32 weeks of gestation and a second specimen at some time thereafter, depending upon the results of the first analysis. Whenever possible, the specimen is tested immediatley. If this is impossible, it is protected from light and refrigerated until the analysis can be performed. The specimen is centrifuged for 10 minutes at 2500 rpm. and filtered in an attempt to remove as much as possible of the particulate matter. Then a 3-ml. aliquot of the fluid is placed in a 1-cm. light path cuvette and analyzed in a spectrophotometer (Beckman DK-2), which automatically records the spectral absorption from 700 to 350 mu.

"The total optical density at 450 mu is calculated by subtracting the optical density at 700 mu from the optical density at 450 mu. Thus far, optical density values of 0.05 or less have been obtained only from uninvolved infants or infants minimally affected by erythroblastosis in which the only evidence of disease has been questionable or 1+ on direct Coomb's test. In every instance when the total optical density at 450 mu has been 0.10 or greater, the infant has had serious involvement with hemolytic disease; all have been significantly anemic, with hemoglobin concentrations (on cord blood) of 10.5 gm per cent or less, and have required exchange transfusion. In those patients in whom the initial amniocentesis value was between 0.05 and 0.10, the interpretation has had to depend upon the trend of the values obtained at subsequent taps. Where the value increased, it has been possible to predict fetal involvement, but where the value decreased, minimal or no involvement eventuated.

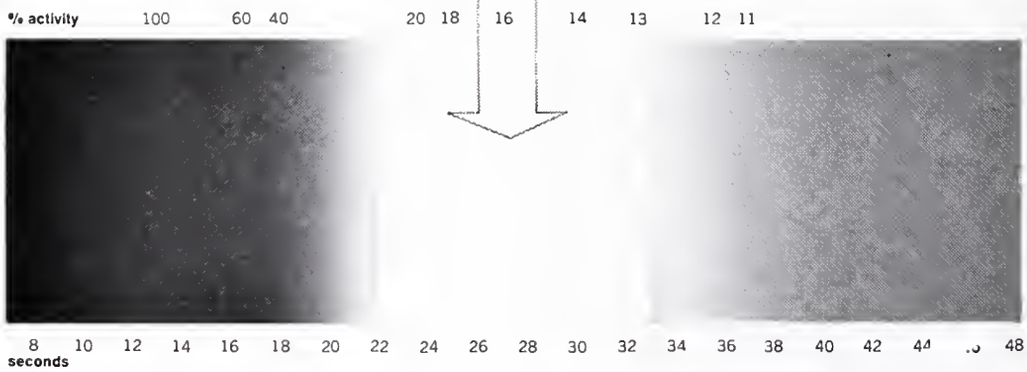
"The procedure is not difficult and has met with ready acceptance by the patients. No maternal or fetal complications have resulted. Contamination of the amniotic fluid by blood has been the most common problem in this procedure. This contamination will alter the spectrophotometric results unless removed as completely as possible by immediate centrifugation." ■

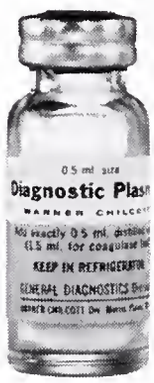
JAMES R. YANO

in prothrombin time testing

this is the critical range

because it's the safety zone for the patient on oral anticoagulants. To prevent the formation of another thrombus, anticoagulants slow the enzyme reactions of coagulation, by depressing the activity of certain clotting factors. As enzyme activity is reduced, the patient's plasma becomes far more sensitive to minor defects in the test system. Such defects (e.g., smudged glassware or a few degrees difference in temperature) are more apt to cause *longer* times than shorter ones. (An erroneously long time reported to the clinician may result in the patient's dosage being reduced to a dangerously low level.) To reveal defects, the control plasma must react with the same sensitivity as the anticoagulated patient's plasma. If it does not, it will not detect a falsely prolonged prothrombin time.





this is the control plasma that works in the critical range

because, in 1+4 dilution, Diagnostic Plasma Warner-Chilcott reacts with the same sensitivity as the anticoagulated patient's plasma. (Not all control plasmas do. To enhance stability, excess clotting factors are added to some. Even when diluted 1+4 they still have sufficient activity to cause prothrombin times to fall near normal.) Diagnostic Plasma Warner-Chilcott should be run routinely in the normal range (undiluted) and in the therapeutic range (in 1+4 dilution). As a normal control it reveals defects in the test system that could affect normal plasma. As a therapeutic control (because in dilution its enzyme activity is comparable to that of the anticoagulated patient) it reveals defects in the test system that could otherwise falsely prolong the prothrombin time of the patient on therapy.

GENERAL DIAGNOSTICS DIVISION
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Hawaii Academy of General Practice

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"status symbol" medicine. As one of our ex-British colleagues says, "We here in America don't realize that the layman in England has never had much of a taste of the luxury brand of medicine, and to him the lack of 'free choice' is like having potato soup as a daily diet, quite satisfying to one who has never had anything better."

The sooner we realize that what we are promoting in American medicine is luxury medicine, the more obvious should it become to laymen and physicians that it cannot be paid for by a mere pittance. It is expensive medicine, too expensive for a social security tax base, too expensive for any except those who can afford it.

By the same token, it behooves us physicians not to price our services out of the market, and to remember that through our own efforts we have promoted an atmosphere conducive to cheap but good medicine which is attractive to so many.

Not "freedom of choice" BUT "freedom of relationship" should be our motto, and—to the layman: "Let your generalist choose your specialist for you."

J. I. FREDERICK REPPUN, M.D.
Secretary-Treasurer

Book Reviews *continued from 477*

treatment of diseases which we might run across one or two times a year or even once in our lifetime of practice. If you are such a physician, which I'm sure you are, then you will find this volume a valuable contribution to your practice.

There are contributions from 248 eminent authorities who, in the opinion of the editors, utilize the best therapeutic procedures currently available. The descriptions are clear, precise, and complete. There is a reference list following each discussion. The volume does not present generalities but strives for preciseness and step-by-step guidance. One can appreciate the painstaking care given to drug descriptions and dosages, diet schedules for special patients, and suggestions in anticipatory guidance. The meticulous indexing of illnesses saves valuable time for the busy practitioner. There seems to be only one drawback for a book as this and that is its lifetime is two years and sometimes it is hard to justify the cost when no sooner than purchased, the book becomes obsolete. Such is the price for medical advancements.

RICHARD K. B. HO, M.D.

The Essentials of Paediatrics for Nurses, 2d Ed.

By I. Kessel, M.B., B.Ch., M.R.C.P. (Lond.), M.R.C.P. (Edin.), D.C.H. (Eng.), 258 pp., $7.00, Williams & Wilkins, 1963.

THE NEW EDITION has attempted to update most of the medical requirements needed by pediatric nurses. The subject matter has been approached from the point of view of the basic principles of this branch of medicine in relation to the modern trends and advances. Some of the subject matter is covered in a very broad way, with a few specifics highlighted. It is interesting to note that many words are spelled differently than we spell them.

continued page 530

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If used as a text for pediatric nursing, it should be augmented with other references.

ROSE ANN POYZER, R.N.

Also Received

Case Studies in Obstetrics and Gynecology

By F. Jackson Stoddard, M.D., 312 pp., $8.50, W. B. Saunders Co., 1964.

AN ANALYSIS of case studies of current interest but with limitations of completeness because of the style used; i.e. questions and answers covering only certain aspects of each case.

Pediatric Therapy

Edited by Harry C. Shirkey, B.S. (Pharm.), M.D., F.A.A.P., 1144 pp., $16.50, The C. V. Mosby Company, 1964.

SEVENTY-TWO CONTRIBUTORS bring an intensely practical and personal approach to bear upon this problem. The quality, while uneven, seems on the whole very high indeed.

Craig and Faust's Clinical Parasitology, 7th Ed.

By Ernest Carroll Faust, A.B., M.A., Ph.D., LL.D., and Paul Farr Russell, M.D., M.P.H., D.Sc., 1099 pp., $16.50, Lea & Febiger, 1964.

A SCHOOL TEXT, primarily. Thoroughly revised since the sixth edition in 1957.

The Physical Dimensions of Consciousness

By Edwin G. Boring, 251 pp., $17.75, Dover Publications, Inc., 1963.

NEUROSURGEONS and neurologists should read this.

Current Problems in Surgery

Treatment of Chest Injuries (Published monthly), $14.00 per year, By Frank C. Spencer, M.D. Yearbook Medical Publishers, Chicago.

BRISK, CURRENT, authoritative monograph on chest injuries. First of a series of monthly issues. They will be available in the Hawaii Medical Library, 1221 Punchbowl Street.

Patient Care and Special Procedures in X-ray Technology, 2d Ed.

By Carol Hocking Vennes, R.N., B.S., and John C. Watson, R. T., 228 pp. $6.25, The C. V. Mosby Company, 1964.

A SECOND EDITION of this useful manual suggests that it is worth radiologists' attention.

★Ciba Foundation Study Group No. 16: The Immunologically Competent Cell—Its Nature and Origin

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., 110 pp., $2.95, Little, Brown & Company, 1963.

CIBA does it again. Though technical and hypothetical in many respects, the presentations and thoughts gathered in this monograph reveal the most current subjects of modern medicine discussed by a most distinguished group of

continued page 532

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REFERENCES: 1. Perlstein, S. M.: Med. Times 86:1238 (Oct.) 1958. 2. Wexler, L.: Clin. Med. 8:505 (March) 1961. 3. Baker, K. C.: Arizona Med. 15:189 (March) 1958. 4. James, B. M., and Hunt, J. A.: Industr. Med. Surg. 27:199 (April) 1958. 5. Montgomery, R. M., and Lavette, W. M.: Clin. Med. 6:29 (Jan.) 1959.

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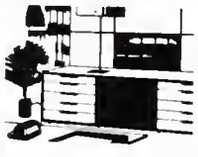
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Book Reviews *continued from 324*

experts. A must for those interested in the basic concepts which may make possible clinical progress in the future, such as successful organ transplants.

★Chemistry and Treatment of Adrenocortical Diseases

By F. T. G. Prunty, M.A., M.D. (Cantab.), F.R.C.P. (London), 380 pp., $14.00, Charles C. Thomas, 1964.

AN EXCELLENT test for clinicians interested in the adrenal cortex and its disorders. Basic biochemical facts, thought somewhat academic and complex, are necessary for clinical comprehension of these uncommon disorders of the adrenal cortex. With this philosophy, Dr. Prunty presents the basic biochemistry and physiology with clarity in order that the practicing clinician may appreciate the subtleties of these clinical disorders. Highly recommended for those who delve in the management of adrenocortical diseases.

The Exceptional Child in the Family

By Alan O. Ross, Ph.D., 230 pp., $6.75, Grune & Stratton, 1964.

AN INTERESTING subject discussed from the psychologist's viewpoint.

New and Nonofficial Drugs—1964

American Medical Association Council on Drugs, 863 pp., $4.00, J. B. Lippincott Company, 1964.

AN EXCELLENT REFERENCE that should be used more frequently.

The Armed Forces Institute of Pathology: Its First Century 1862-1962

By Robert S. Henry, A.B., LL.B., Litt.D., 422 pp., $4.25, U. S. Government Printing Office, 1964.

A HISTORICAL background of one of our most respected institutions whose contribution to military as well as civilian medicine has been outstanding.

Marriage Counseling in Medical Practice: A Symposium

Edited by Ethel M. Nash, M.A., Lucie Jessner, M.D., and D. Wilfred Abse, M.D., 368 pp., $8.00, University of North Carolina Press, 1964.

A RATHER COMPREHENSIVE study of one of the common perplexing problems encountered by most physicians.

Ciba Foundation Symposium: Disorders of Language

Edited by A. V. S. De Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A., 356 pp., $11.00, Little, Brown & Company, 1964.

AN EXCELLENT symposium concerned with aphasia and its complexities.

★Handbook of Legal Medicine, 2d Ed.

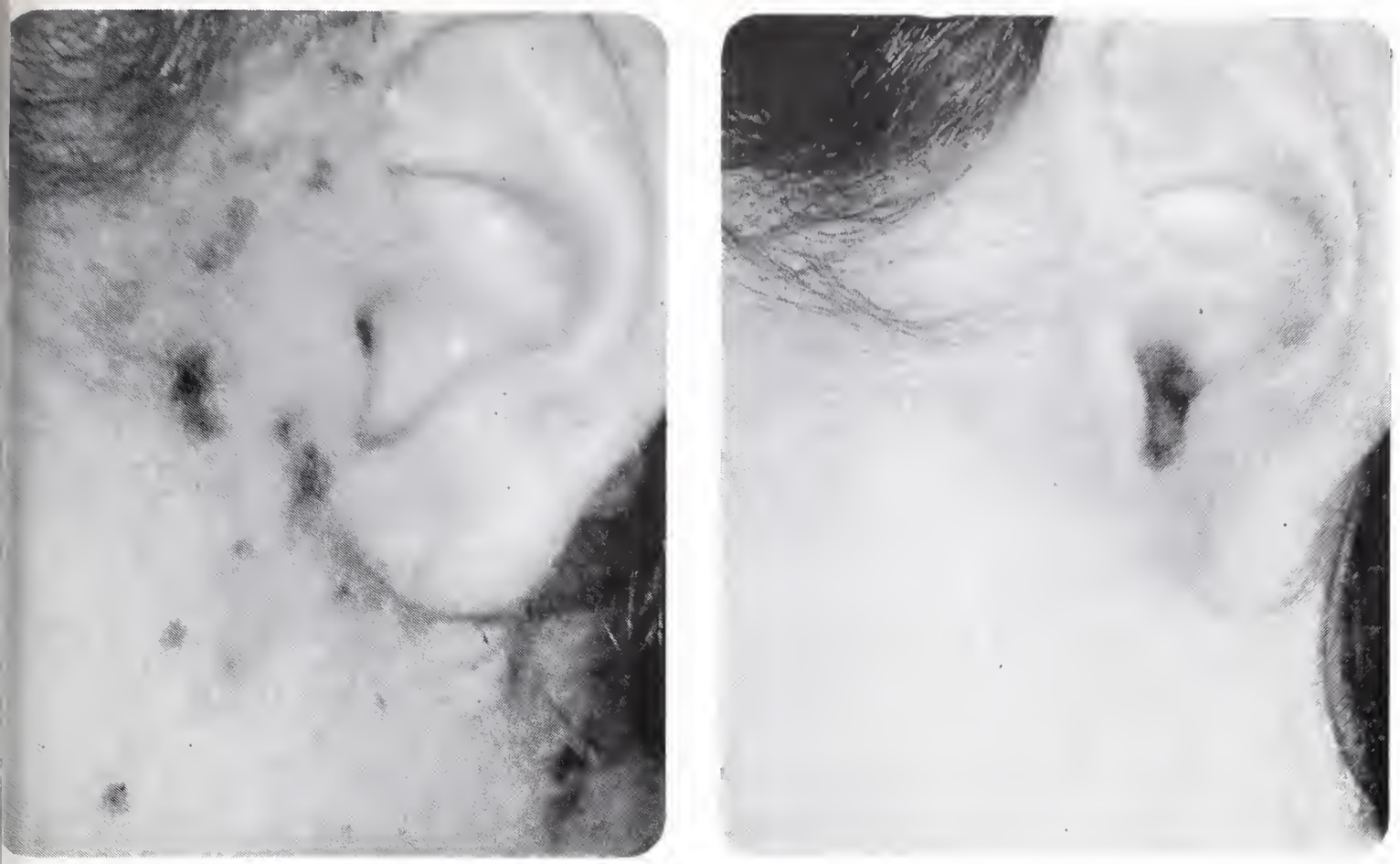
By Alan R. Moritz, M.D., and C. Joseph Stetler, LL.B., LL.M., 239 pp., $5.75, The C. V. Mosby Company, 1964.

THE SUBJECT MATTER is of current interest and is a good introduction to the relationship of law and medicine. These 218 pages are readable as well as informative for those not versed in the legal aspects of medicine.

★Current Therapy 1964

By Howard F. Conn, M.D., 797 pp., $13.00, W. B. Saunders Company, 1964.

AGAIN, an excellent reference source on current therapy for clinicians. The list of contributors is impressive. ■



B. B., Age 10—atopic dermatitis all her life...and after two weeks of treatment.

Case History: B. B. is a 10-year old girl with a life-long history of atopic dermatitis. Previous diet therapy, lamp treatment, and antihistamine were of no avail. First photograph shows a severely excoriated, eczematized area with intractable pruritus. ARISTOCORT® Triamcinolone Acetonide 0.1% Cream was prescribed, and relief was obtained in 24 hours. Follow-up photo was taken two weeks later.

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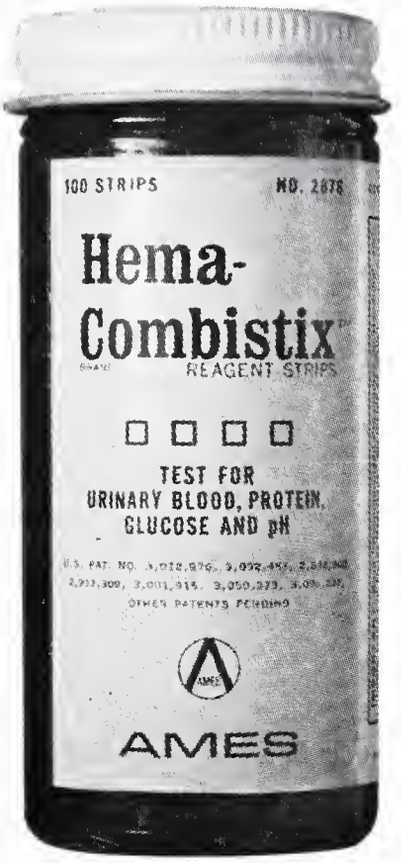
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Effectiveness: Specific for estrogen replacement therapy in the menopause and postmenopause. **Usual dosage:** 1.25 mg. daily. Increase or decrease as required. **Caution:** *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period). *In the male:* Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.

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